

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10-1-64
30M REV. 3-7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Naomi SPEICE Abbott			2a. DATE OF DEATH Month 4- Day 3 Year 68			2b. HOUR 6:30AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-12-97		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.					
10. CITY OR TOWN OF DEATH Baltimore CO.		11. NAME OF HOSPITAL OR INSTITUTION (If in hospital give street address) HILLDALE 6615 ELSMERE PL. APTS.		12a. USUAL OCCUPATION (Kind of work done during week immediately preceding death, or if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO. CO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 21234 6615 ELSMERE PLACE.			
14. FATHER'S NAME First Middle Last WILLIAM C. SPEICE				15. MOTHER'S MAIDEN NAME First Middle Last UNK.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 017-26-8329 B		17. INFORMANT WM E. ABBOTT AS IN 13 a-b-c-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes year											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331X Congestive heart failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Sept 1963, to April 1968, that (I) (we) last saw the deceased alive on 3/27/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. F. Palmisano MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-3-68			
22d. PHYSICIAN'S NAME (Type) J. F. Palmisano, M. D.				22e. ADDRESS 6608 Loch Raven Blvd. Balto. 21212							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE APRIL 3, 68		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CRE.		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.					
24. FUNERAL DIRECTOR W. Brooks Bradley				ADDRESS DUNDALK, MD.		25a. RECEIVED BY REGISTRAR APR 5 - 1968		REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 21a-21f film 399 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05164

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05168

1. DECEASED-NAME (Type or Print) Douglas Edward Ahrens			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR April 11 1968			2b. HOUR 10 PM		
3. SEX M	4. RACE W	5. DATE OF BIRTH 12/18/1951	6. AGE (In years last birthday) 16 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 11 1968
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student - Northern High Sch		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN 12		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1254 Meridene Drive
14. FATHER'S NAME First Middle Last Richard B. Ahrens			15. MOTHER'S MAIDEN NAME First Middle Last Gloria P. Ansel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Richard B. Ahrens			ADDRESS (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury of Skull DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8244								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 4-11 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Thrown from auto which rolled on his head				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. Phoenix		City or Town Baltimore		State Md
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell		EXAMINER'S NAME (Type) Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED April 11, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Grds. Timonium, Balto. Co. Md.		23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.		
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

05163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13 Film G399 4/10/68 kkk

CERTIFICATE OF DEATH

05164

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
Tekla		Aizkrauklis			4-2-68				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	W		Jan. 5, 1904		64 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Latvia		U.S.A.				Balto., Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Mt. Wilson			Mt. Wilson Hosp.		None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Mt. Wilson, Md.			Balto.		Mt. Wilson				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Jekabs Ivans			Alvine Kimenis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			None		Dr. Valdis, Mt. Wilson, Md. 21112				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 mos</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension arteriosclerotic cardio vascular disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>67</u> , to <u>4/2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Alfred H Ossman M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-2-68</u>		
22d. PHYSICIAN'S NAME (Type) Alfred Ossman					22e. ADDRESS 1101 St. Paul St., Balto., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Cremation		4-4-68		Loudon Park Cemetery		Balto., Md.			
24. FUNERAL DIRECTOR ADDRESS Witzke Funeral Directors, Balto., Md. 21229					25a. REC'D BY REGISTRAR DATE APR 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05166												05170											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												CERTIFICATE OF DEATH											
Item 1 Film G399 4/26/68 Kc																							
1. DECEASED-NAME (Type or print) WILLIAM				First F. S. Middle AMRHINE Last				2a. DATE OF DEATH 4/17/68 Month Day Year				2b. HOUR M											
3. SEX Male				4. RACE White				5. DATE OF BIRTH Dec. 5, 1889				6. AGE (In years last birthday) 78 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore Md.											
10. CITY OR TOWN OF DEATH Catonsville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caton Ridge Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Carpenter				12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Parkville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 2617 Taylor Ave.							
14. FATHER'S NAME First Charles Middle H Last Amrhine				15. MOTHER'S MAIDEN NAME First Emma Middle Kummer Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 212-10-6407				17. INFORMANT Mr Kenneth W Amrhine				Address 1210 Havenwood Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Bronchopneumonia 440.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ② (b) Generalized Arteriosclerosis & Chronic DUE TO, OR AS A CONSEQUENCE OF (c) Brain Syndrome												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 9-21-1967 , to 4-17-1968 , that (I) (we) last saw the deceased alive on 4-17-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Cesar Valle Caverio DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED 4-18-68											
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERIO												22e. ADDRESS 3629 Liberty Rd.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/20/68				23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore Md. 21214												25a. REC'D BY REGISTRAR DATE APR 22 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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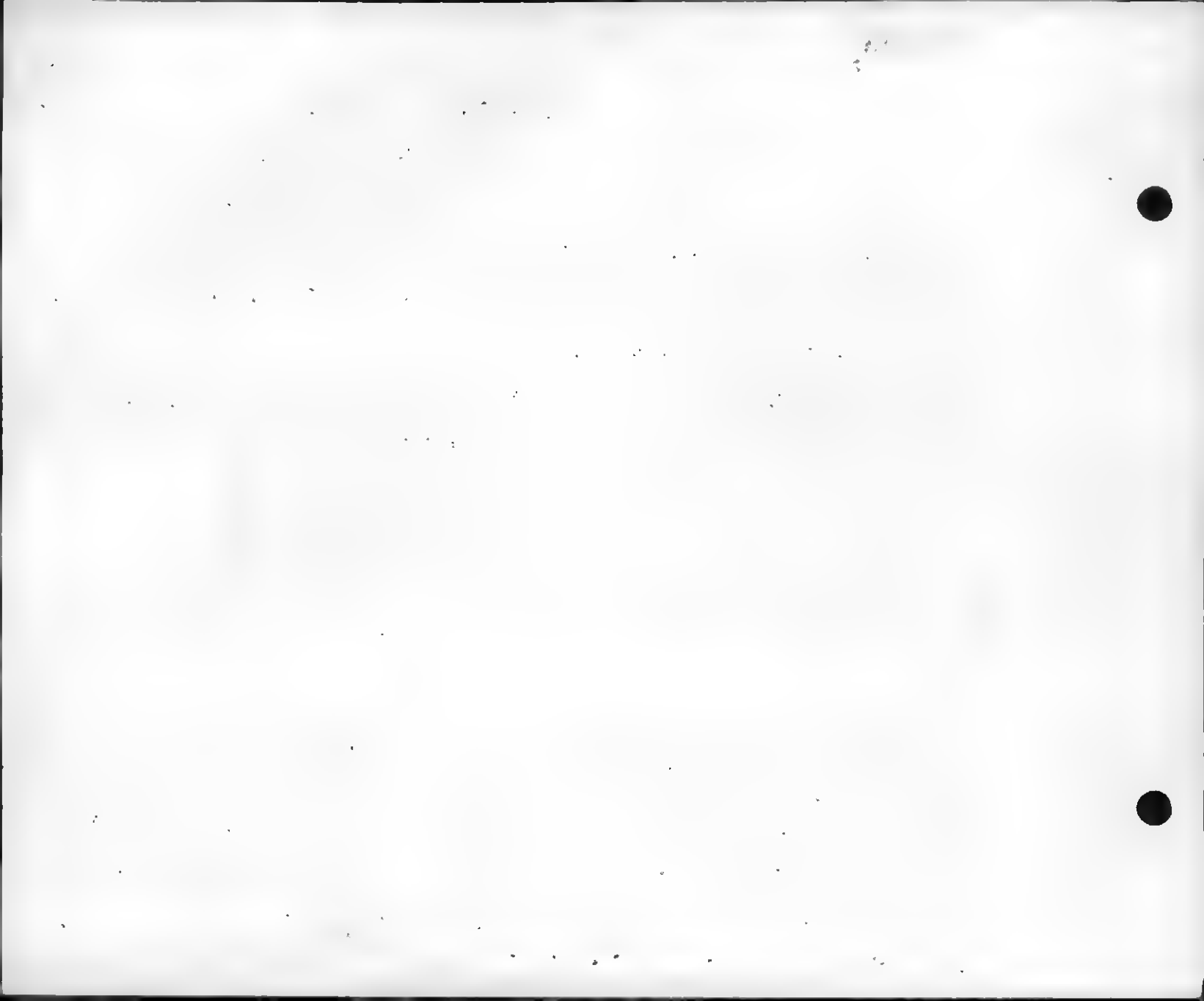
05167												05171																			
1. DECEASED-NAME (Type or print)												2a. DATE OF DEATH																			
First				Middle				Last				Month				Day				Year				2b. HOUR							
ADELAIDE				MARIE				ANDERSON				April				23				1968				5:15PM							
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				7. IF UNDER 1 YEAR				8. IF UNDER 24 HRS.											
Female				White								42				MONTHS				DAYS				HOURS				MIN			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																			
Kentucky				USA								Baltimore, Md.																			
1d. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY																			
Baltimore, Maryland				Greater Balto. Med. Cen.				Housewife				Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER															
Maryland				Baltimore								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				24 Summit Avenue															
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																											
First				Middle				First				Middle				Last															
Harry A. Macbrair				Elizabeth M Parrott																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT Address																							
No				403 26 1145				Mrs. Dorothy K. Davis 44 Windmoor Place.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY:																															
IMMEDIATE CAUSE (a) Cor pulmonale and respiratory insufficiency																															
DUE TO, OR AS A CONSEQUENCE OF																															
(b) Pulmonary metastases																															
DUE TO, OR AS A CONSEQUENCE OF																															
(c) Osteogenic sarcoma of right knee																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																															
199.2 Amputation right leg																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
1965				Osteosarcoma				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				Yes																			
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. Month Day Year																											
(If either, notify medical examiner)				P.M. 19																											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																							
While <input type="checkbox"/> Not while <input type="checkbox"/>				()																											
at work <input type="checkbox"/> at work <input type="checkbox"/>																															
22a. I certify that (I) (this hospital) attended the deceased from March 26, 1968, to April 23, 1968, that (I) (we) last saw the deceased alive on April 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																															
22b. SIGNATURE												22c. DATE SIGNED																			
John E. Adams												April 23, 1968																			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																			
JOHN E. ADAMS, M.D.												Greater Baltimore Medical Center																			
23a. BURIAL, CREMATION, REINTERMENT				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																			
Buried				4-26-68				Lake View Mem.Pk. Cem.				Balto. Co. Maryland																			
24. FUNERAL DIRECTOR ADDRESS												25a. REC'D BY REGISTRAR DATE				25b. REGISTRAR'S SIGNATURE															
Wm. E. Johnson 8521 Loch Raven Blvd. Balto. 21204												APR 26 1968				Charles Judge															

John A. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>05168</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>05172</div>																
1. DECEASED NAME (Type or print)			First Martin			Middle Applebaum			Last Applebaum			2a. DATE OF DEATH Month Day Year April 29 68		2b. HOUR 9:50 AM		
3 SEX Male			4. RACE White			5. DATE OF BIRTH August 2, 1923			6. AGE (In years last birthday) 44 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Baltimore			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED: WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.							
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Court Reporter			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 24 Maryland Avenue #21208				
14. FATHER'S NAME First Middle Last ELLIS Applebaum			15. MOTHER'S MAIDEN NAME First Middle Last Rebecca													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO. W 10 11			17. INFORMANT MRS FLORENE APPLEBAUM			Address SAME							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State	
22a. I certify that (I) (this hospital) attended the deceased from 4-26, 1968, to 4-29, 1968, that (I) (we) last saw the deceased alive on 4-29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Elmo Gayoso			DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 4-29-68										
22d. PHYSICIAN'S NAME (Type) Elmo Gayoso, M.D.			22e. ADDRESS 7620 York Road, Baltimore, Md. 21204													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/30/68			23c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery			23d. LOCATION (City or Town) (County) (State) B. Vt. Md.							
24. FUNERAL DIRECTOR Sydney S. Lewis & Son, Inc			ADDRESS 9610 Reisterstown Rd			25a. REC'D BY REGISTRAR DATE APR 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge							

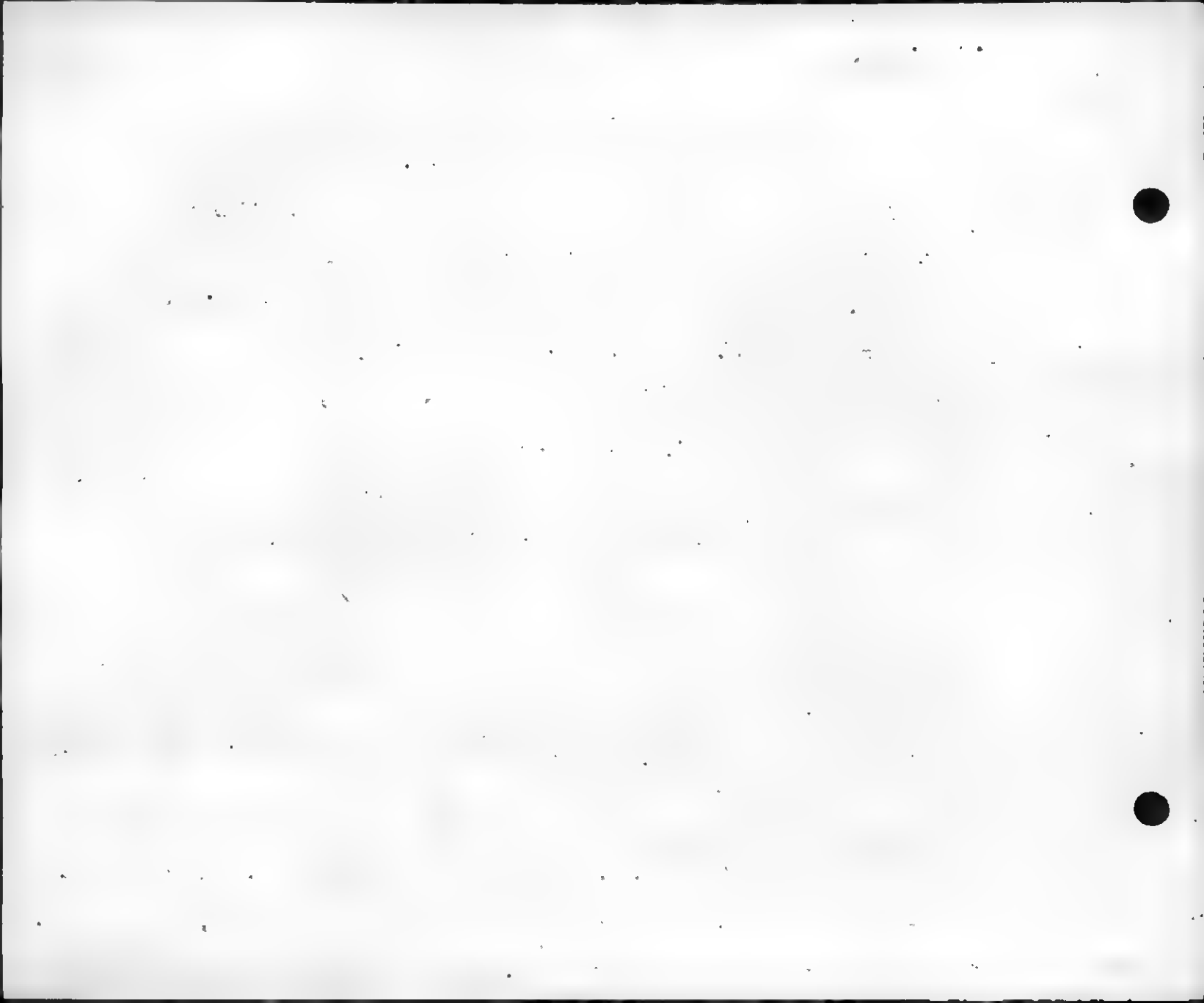


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First Thelma	Middle Eleanor	Last Armiger	2a DATE OF DEATH Month Day Year April 22, 1968		2b HOUR 8:30 AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 1 Sept. 1910		6 AGE (In years last birthday) 57 YRS		FUNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangri La Nursing Home		12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 402 Westgate Road	
14. FATHER'S NAME First Middle Last Marle J. Carmine		15. MOTHER'S MAIDEN NAME First Middle Last Eleanor Neal		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 216-28-0361		17 INFORMANT James B. Armiger, same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Probable Septicemia 594X DUE TO, OR AS A CONSEQUENCE OF (b) Decubiti, German tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Bladder Cancer - Severe Peritonitis Approximate Interval Between Onset and Death Days Months Years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) this hospital attended the deceased from 1960, 19, to 4/22, 1968, that (I) was lost saw the deceased alive on 4/18, 1968, and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.									
22b. SIGNATURE James J. Nolan				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/23/68			
22d. PHYSICIAN'S NAME (Type) James J. Nolan, M. D.				22e. ADDRESS 1 Hallowhill Ave., Baltimore, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 25 April		23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.				25a REC'D BY REGISTRAR DATE APR 24 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

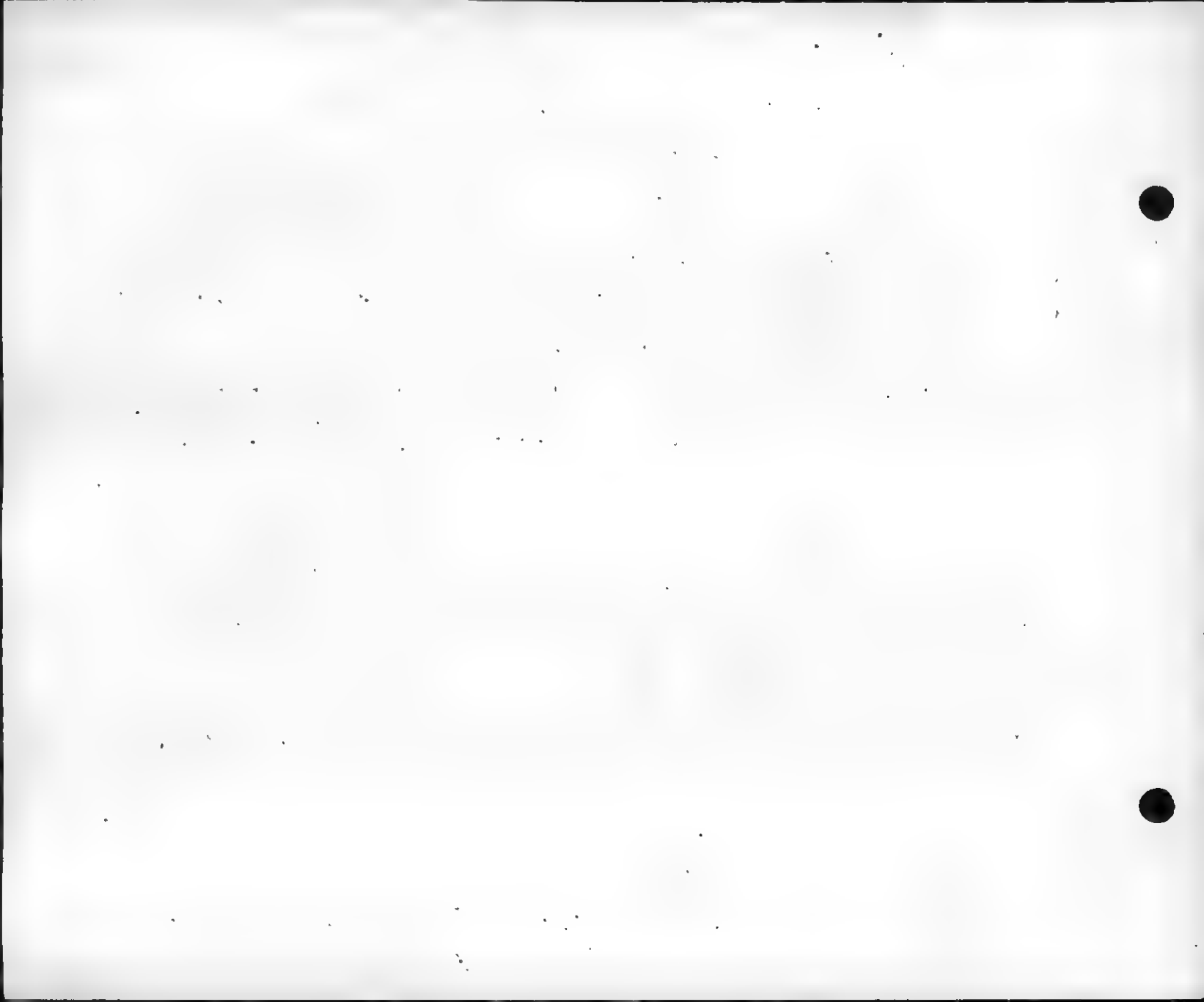
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 400 (10)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item 1 File G399 4/16/68 kk												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) Edward F. ARMSTRONG						2a. DATE OF DEATH Month 4 / Day 10 / Year 68			2b. HOUR 2:40 AM			
3. SEX male		4. RACE white		5. DATE OF BIRTH 3/15/83			6. AGE (in years last birthday) 85 YRS		7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md						
10. CITY OR TOWN OF DEATH Mount Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Plant Foreman			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.			13b. COUNTY Montgomery Silver Spring			13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8505 Springdale		
14. FATHER'S NAME First Edward Middle Last Armstrong				15. MOTHER'S MAIDEN NAME First Regina Middle Last Hall								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO 216-07-6531		17. INFORMANT Address Records, Mt. Wilson State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). Pulmonary fibrosis, interstitial												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary TB, End arteriosclerosis, mitral												
DUE TO, OR AS A CONSEQUENCE OF (b) 												
DUE TO, OR AS A CONSEQUENCE OF (c) 												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Atherosclerotic Heart Disease, Pulm. Hbc												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Day Year P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State 								
22a. I certify that (I) (this hospital) attended the deceased from 3/20/1968 , to 4/10/1968 , that (I) (we) lost saw the deceased alive on 4/10/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Newcomer						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10 April '68				
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 13 April		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.						
24. FUNERAL DIRECTOR IRKLEY Funeral Home, Glen Burnie, Md.				ADDRESS 		25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION

Detritus MD



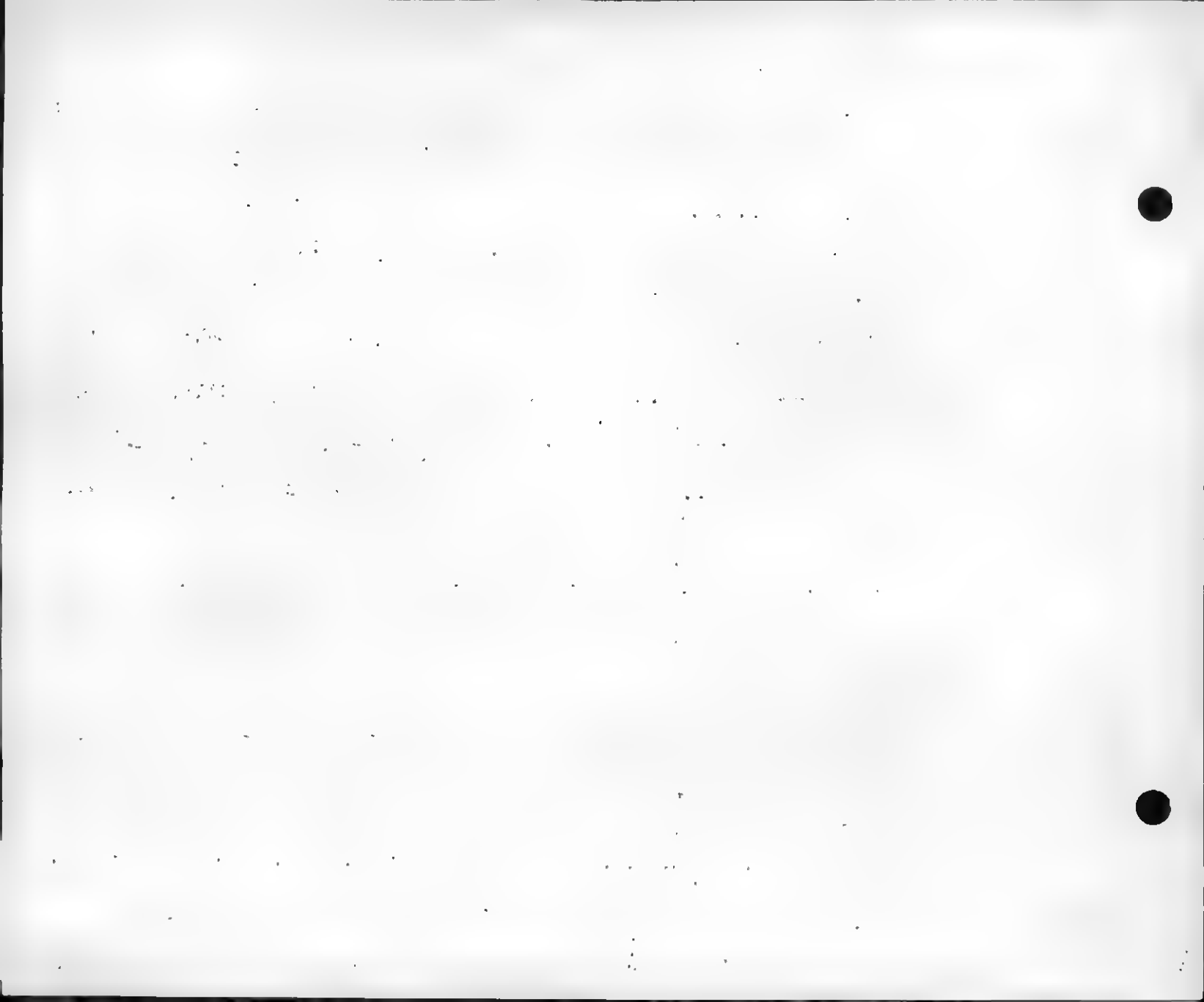
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Gilbert Lane ATHEY			2a DATE OF DEATH Month 4 Day 22 Year 68			2b HOUR 8:50 a m	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 7/27/57		6 AGE (In years last birthday) 10 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood State Hosp.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Dependent		12b KIND OF BUSINESS OR INDUSTRY none	
13a USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE Md.		13b COUNTY Howard		13c CITY OR TOWN Simpsonville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 114 Hunting Lane							
14 FATHER'S NAME First Gilbert Middle Roy Last Athey			15 MOTHER'S MAIDEN NAME First Margaret Middle Jeanne Last O'Neill				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no (If yes give war or dates of service) ---		16b SOCIAL SECURITY NO none		17 INFORMANT Address Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Orthostatic Necrotizing Pneumonia DUE TO, OR AS A CONSEQUENCE OF Repeated Aspiration of Stomach Contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months (c) 6 months							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Encephalopathy with severe mental retardation							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 11/21 , 19 67 , to 4/22 , 19 68 , that (X) (we) last saw the deceased alive on 4/22 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard A. Jones				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/22/68	
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.				22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-25-68		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel Md	
24. FUNERAL DIRECTOR William Donaldson		ADDRESS Laurel Md		25a. RECEIVED BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

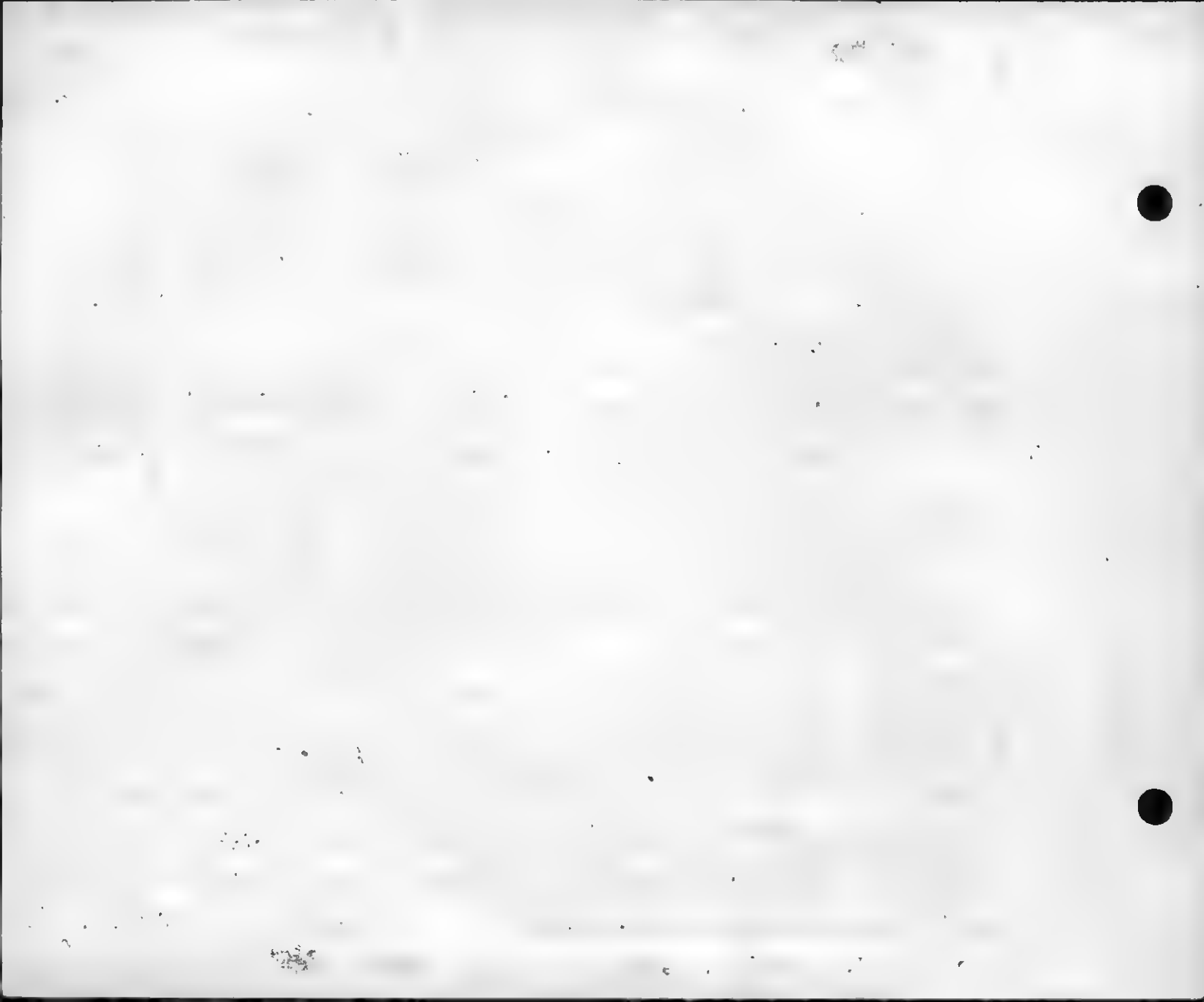


MIDDLE
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) AGNES R. BACHMAN			2a DATE OF DEATH April 22, 1968		2b HOUR 9:15 A.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH 6/26/1883		6 AGE (In years last birthday) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		12b. KIND OF BUSINESS OR INDUSTRY
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2601 Harford Rd.
14 FATHER'S NAME First Middle Last Edward R. Roach			15. MOTHER'S MAIDEN NAME First Middle Last Mary Lynch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address Mr. John S. Bachman - Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure 182.4 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1 June, 1968 to 23 Apr, 1968 , that (I) (we) last saw the deceased alive on 23 Apr, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William Goodman MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 23 Apr 68	
22d. PHYSICIAN'S NAME (Type) Dr. William Goodman				22e. ADDRESS 1334 Sulphur Spring Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/25/68	23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City or Town) (County) (State) Long Green, Balto. Md.	
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Baltimore 21214				25a. RECD BY REGISTRAR APR 25 1968 25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0517 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Warren W. Baer		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 4/13/68		2b HOUR 3:50 PM
3 SEX M	4 RACE W	5 DATE OF BIRTH 4/10/02	6 AGE (in years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) PENNA.		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Ba / Ho.
10 CITY OR TOWN OF DEATH RANDALLS TOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTIMORE COUNTY GEN. HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) UNDERWRITER
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE PENNA.		13b COUNTY Phila.	13c CITY OR TOWN Phila.	13d INSIDE CITY L.M.S.? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14 FATHER'S NAME First FREDERICK E. Middle BACR Last BACR		15 MOTHER'S MAIDEN NAME First Elizabeth Middle SCHAEFFER Last SCHAEFFER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. ?		17 INFORMANT HAROLD BAER
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-vascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE James N. Frederick		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/13/68
EXAMINER'S NAME (Type) James N. Frederick MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) Ba / Ho.
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b DATE 4/17/68	23c NAME OF CEMETERY OR CREMATORY MT. PLEACE	23d LOCATION (City or Town) (County) (State) PHILA. PA.	
24. FUNERAL DIRECTOR MANNAL Funeral Home		ADDRESS Phila. PA.		25a. REC'D BY REG. STRAR APR 16 1968
E. B. McHale		Catonsville Md.		25b. REG. STRAR'S SIGNATURE Charles Judge



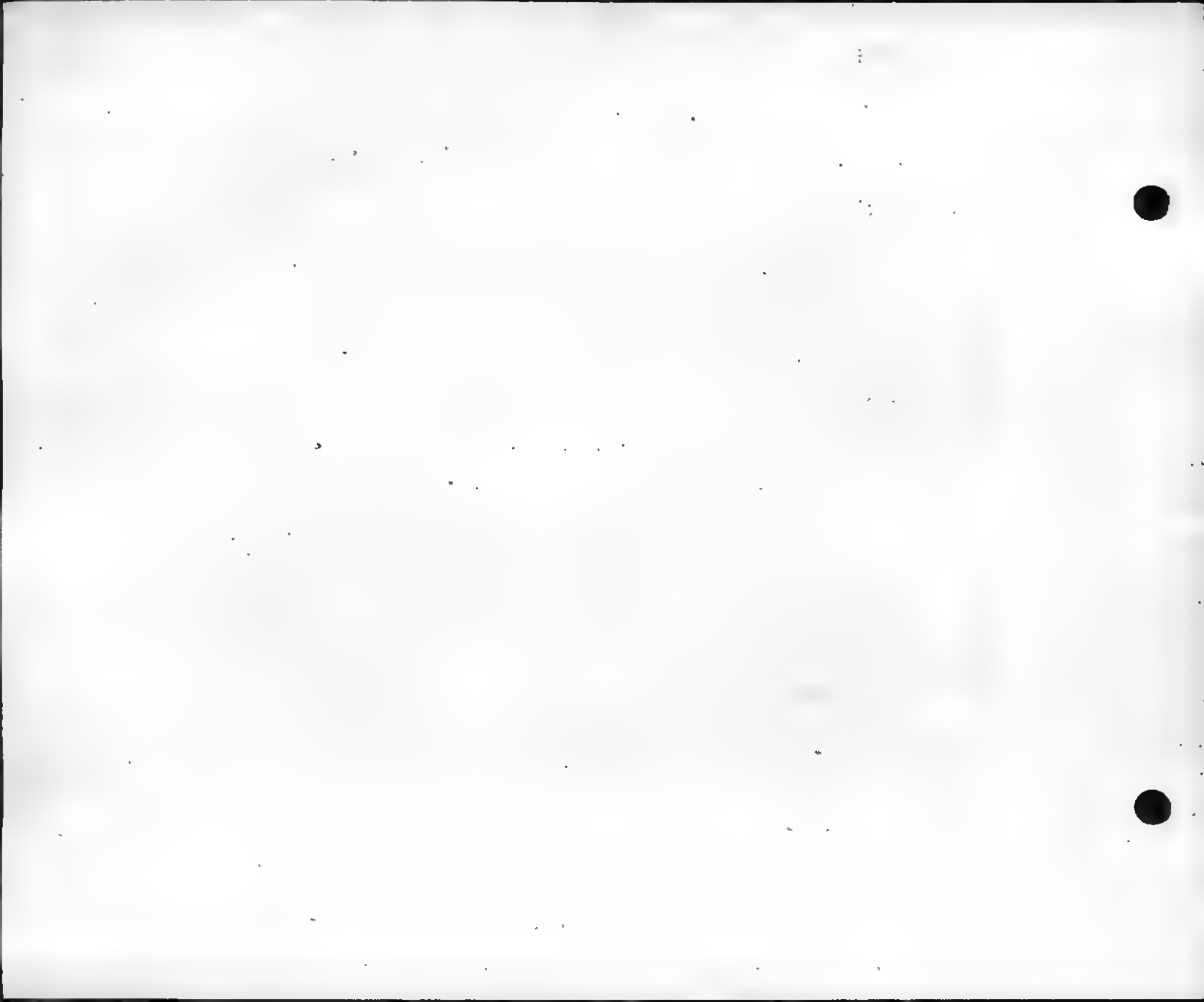
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

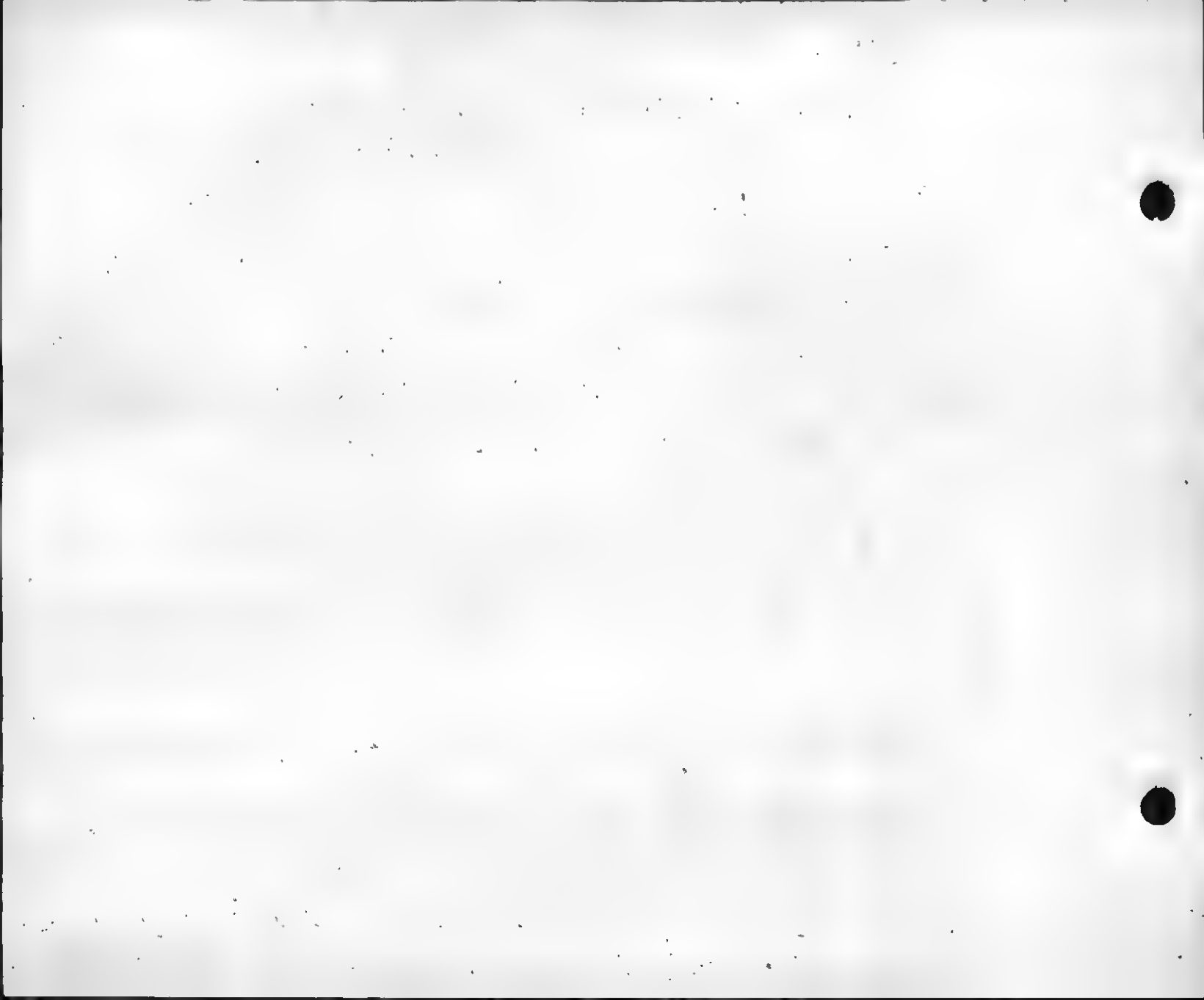
1 DECEASED-NAME (Type or print) <i>Thomas</i> First <i>Archer</i> Middle <i>Bailey</i> Last			2a. DATE OF DEATH Month <i>4</i> Day <i>28</i> Year <i>68</i>			2b. HOUR <i>12:50</i> MIN <i>AM</i>			
3 SEX <i>Male</i>		4 RACE <i>Cauc</i>		5 DATE OF BIRTH <i>1/16/1895</i>		6 AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Balto.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTO</i> Md.			
10. CITY OR TOWN OF DEATH <i>Towson, Ind 21204</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Queen Balto Med Center</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>XXXXXXXXXX Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Balto</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>4413 Marble Hall Rd.</i>			
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Bailey</i> Last			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>---</i> Last <i>---</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>XXXXXXXXXX WW I</i>		16b. SOCIAL SECURITY NO <i>215037531</i>		17 INFORMANT <i>PATIENTS CHART</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubration</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Intracranial bleeding</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>SIX</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4-27, 1968</i> to <i>4-28, 1968</i> , that (I) (we) last saw the deceased alive on <i>4-28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. M. deCastro</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED <i>4-28-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. J. M. deCastro</i>						22e. ADDRESS <i>GBMC</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>5-1-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Balto. City, Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks, Inc. 1217 St. Paul St. 21202</i>				25a. REC'D BY REGISTRAR DATE <i>APR 29 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ^{First} <u>Gerry</u> ^{Middle} <u>McDonald</u> ^{Last} <u>Baldwin</u>						2a. DATE OF DEATH <u>April</u> Month <u>13</u> Day <u>68</u> Year			2b. HOUR <u>11:10 P.M.</u>		
3 SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>May 10, 1899</u>		6. AGE (In years last birthday) <u>68</u> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Penn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Balto.</u> Md					
10. CITY OR TOWN OF DEATH <u>White Hall</u>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <u>Egg Salesman</u>			12b. KIND OF BUSINESS OR IND. <u>Egg Bus.</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>			13b. COUNTY <u>Balto.</u>		13c. CITY OR TOWN <u>White Hall</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME ^{First} <u>Dr. Thomas C.</u> ^{Middle} <u>Baldwin</u> ^{Last}				15. MOTHER'S MAIDEN NAME ^{First} <u>Rozella.</u> ^{Middle} <u>McDonald</u> ^{Last}							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>216-38-3805</u>		17. INFORMANT <u>Marjorie C. Baldwin, White Hall, Md.</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Infarction</u> <u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>68</u> , to <u>4/13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Michael Mueller MD</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>4-16-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>e HERBERT HOELLER</u>						22e. ADDRESS <u>PARKTOWN - MD - 21120</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4/17/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centre Presbyterian Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>New Park, Penna.</u>					
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>APR 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

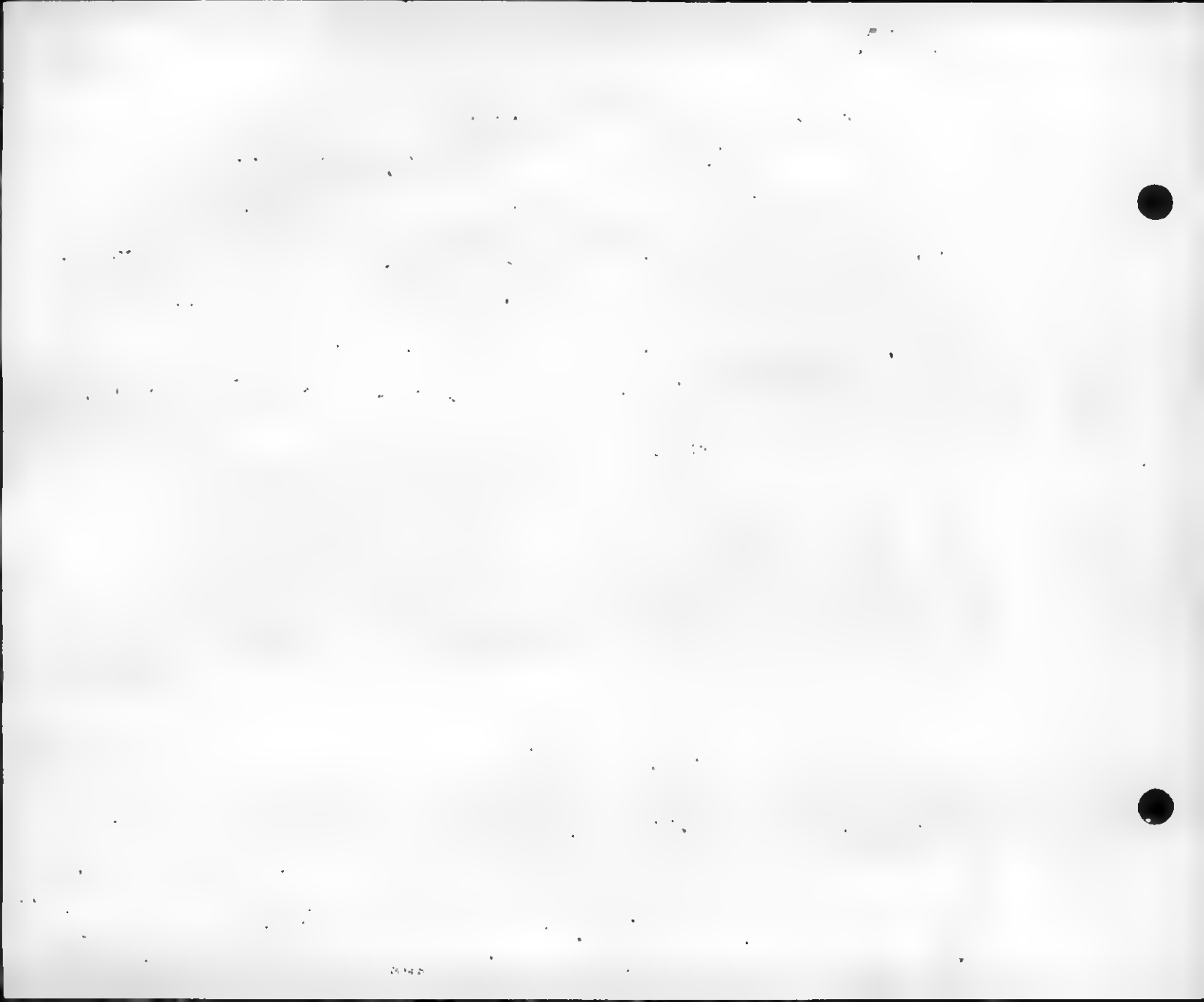


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4-17-68
30M REV 11-68

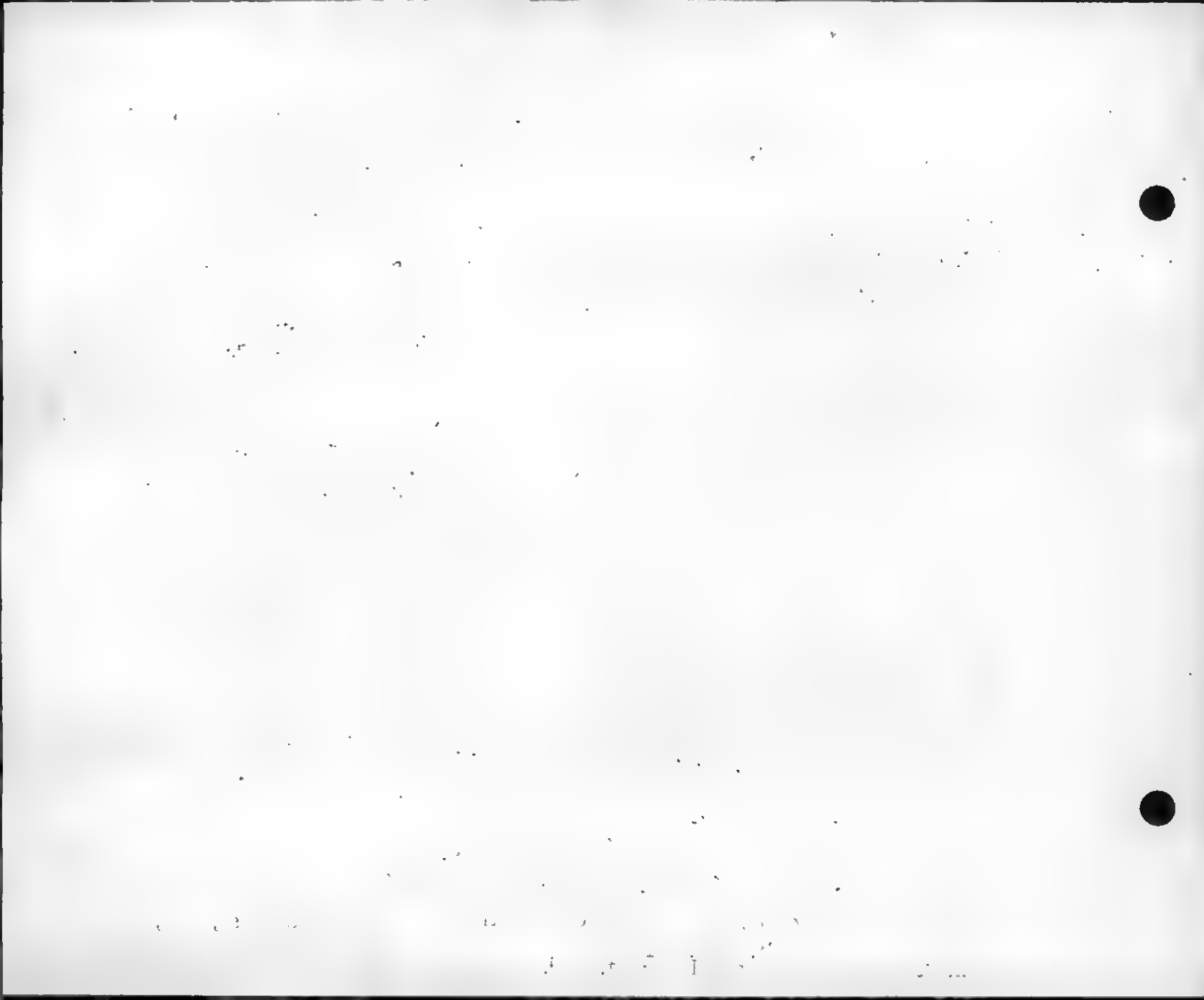
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) First Middle Last Howard Clifton Barker					2a. DATE OF DEATH Month Day Year 4 17 68			2b. HOUR 4 a M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH July 27, 1890		6 AGE (in years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Conductor		12b. KIND OF BUSINESS OR INDUSTRY Transit		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY, L.P. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 2	
14. FATHER'S NAME First Middle Last Jeremiah Barker					15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No -			16b. SOCIAL SECURITY NO. 213-10-1136		17. INFORMANT Mrs. Beatrice Scott		Address Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from July 29, 1965, to April 16, 1968, that (I) (we) lost saw the deceased alive on April 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Naci N. Buyukunsal, M.D.					22c. DATE SIGNED 4-17-68			22d. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 4-20-68		23c. NAME OF CEMETERY OR CREMATORY Good Sheppard Cemetery		23d. LOCATION (City or Town) (County) (State) Md. Sykesville, Edinboro City	
24. FUNERAL DIRECTOR Harry W. Haight					ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR DATE APR 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Cecilia			Basil			April 30 1968			M			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		February 17, 1885			83 YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Md.			U.S.						Baltimore Md			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)				
Cockeysville				Md. Masonic Home				Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INS. DE. CITY LIMITS?		
Md.				Annapolis				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
										22 Madison Rd.		
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last			
Jesse			Wilson			Jane Clara			Ritch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17 INFORMANT				
				215-56-5423-21				Records of Md. Masonic Home Cockeysville				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral arteriosclerosis hemorrhage												
DUE TO, OR AS A CONSEQUENCE OF Directly Mediated												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
160X												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			HOUR A.M. Month Day Year P.M. 19									
22. INJURY OCCURRED			21a. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												
22a. I certify that (I) (this hospital) attended the deceased from April 1965, to April 30, 1968, that (I) (we) last saw the deceased alive on April 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 6-AM. 4/30/68												
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
TAMMIS HANCOCK										4/30/68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
TAMMIS HANCOCK						MASONIC HOME						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			5/2/68		Cedar Bluff			Annapolis, Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REG. STRAIGHT SIGNATURE				
6212 Balt. Nat. Pike Wm. Cook-Brooks West Inc Balt. Md. 21228						DATE MAY 6 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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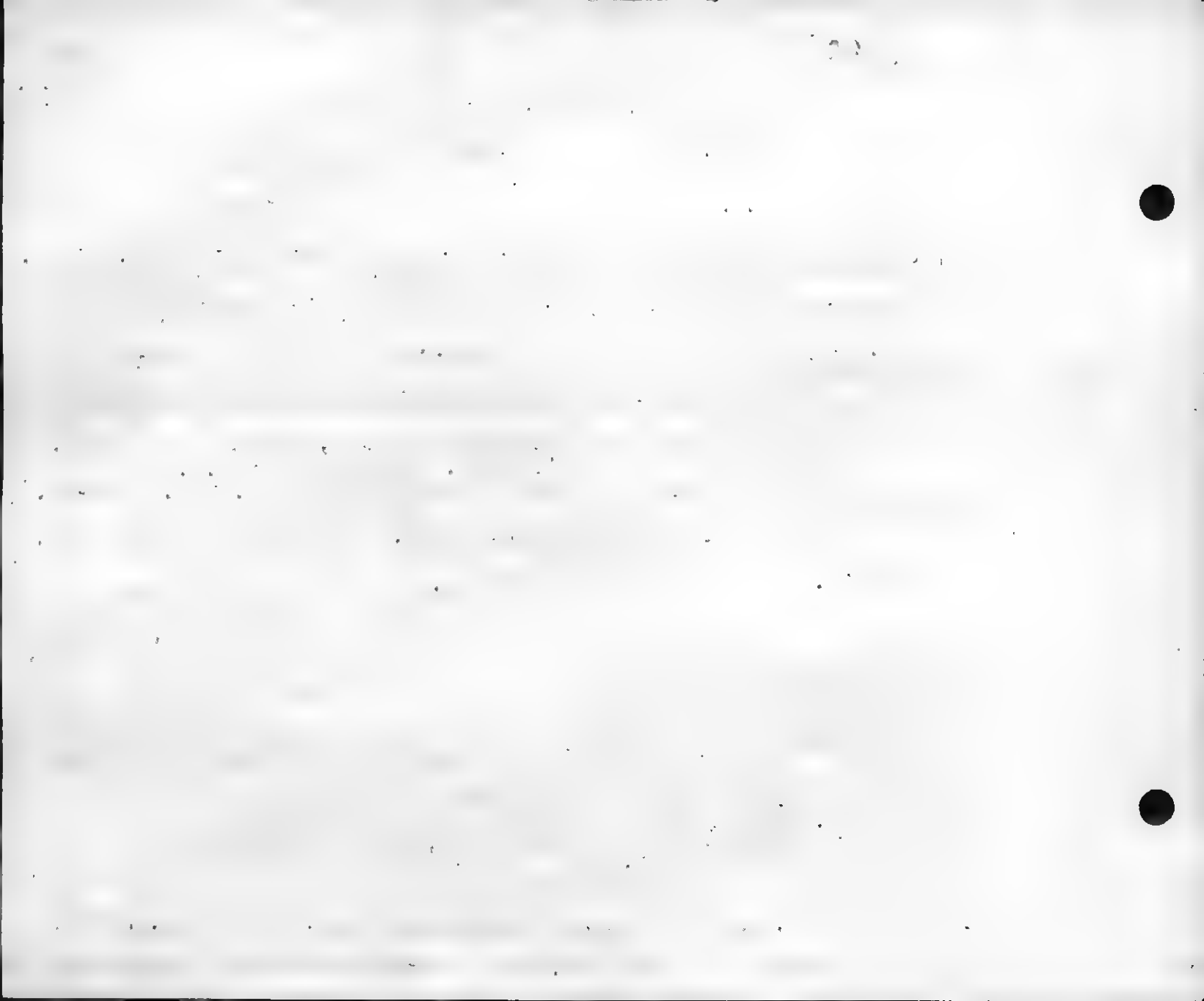
VR A15-1
30M REV 11-68

05178

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Ellis		First Ellis	Middle L.	Last Beavin	2a. DATE OF DEATH April Month 4 , Day 1968		2b. HOUR 11:45		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/29/02		6. AGE (n years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Spring Grove State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) letterer & grainer		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 16 Woodlawn Avenue	
14. FATHER'S NAME First Elmo Middle Beavin Last Beavin				15. MOTHER'S MAIDEN NAME First Lula Middle Scott Last Scott					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213-30-0689		17. INFORMANT Address Records: Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death DUE TO, OR AS A CONSEQUENCE OF with prev. diaphragmatic M.I. (b) Arteriosclerotic Cardiovascular Ht. Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Senile								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 2 hrs. 10 yrs. 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia, recent, treated, improved.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/27/ 19 61 to 4/4/ 19 68 , that (I) (we) last saw the deceased alive on 4/4/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Anthony J. Young, M.D. DEGREE ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS PHYS DIRECTOR PHYS						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.						22e. ADDRESS Spring Grove State Hospital			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE Apr. 6, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis A.A. Md.			
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME - Annapolis, Md.				25a. REC'D BY REGISTRAR DATE APR 8 - 1968		25b. REGISTRAR'S SIGNATURE Johnas Judge			

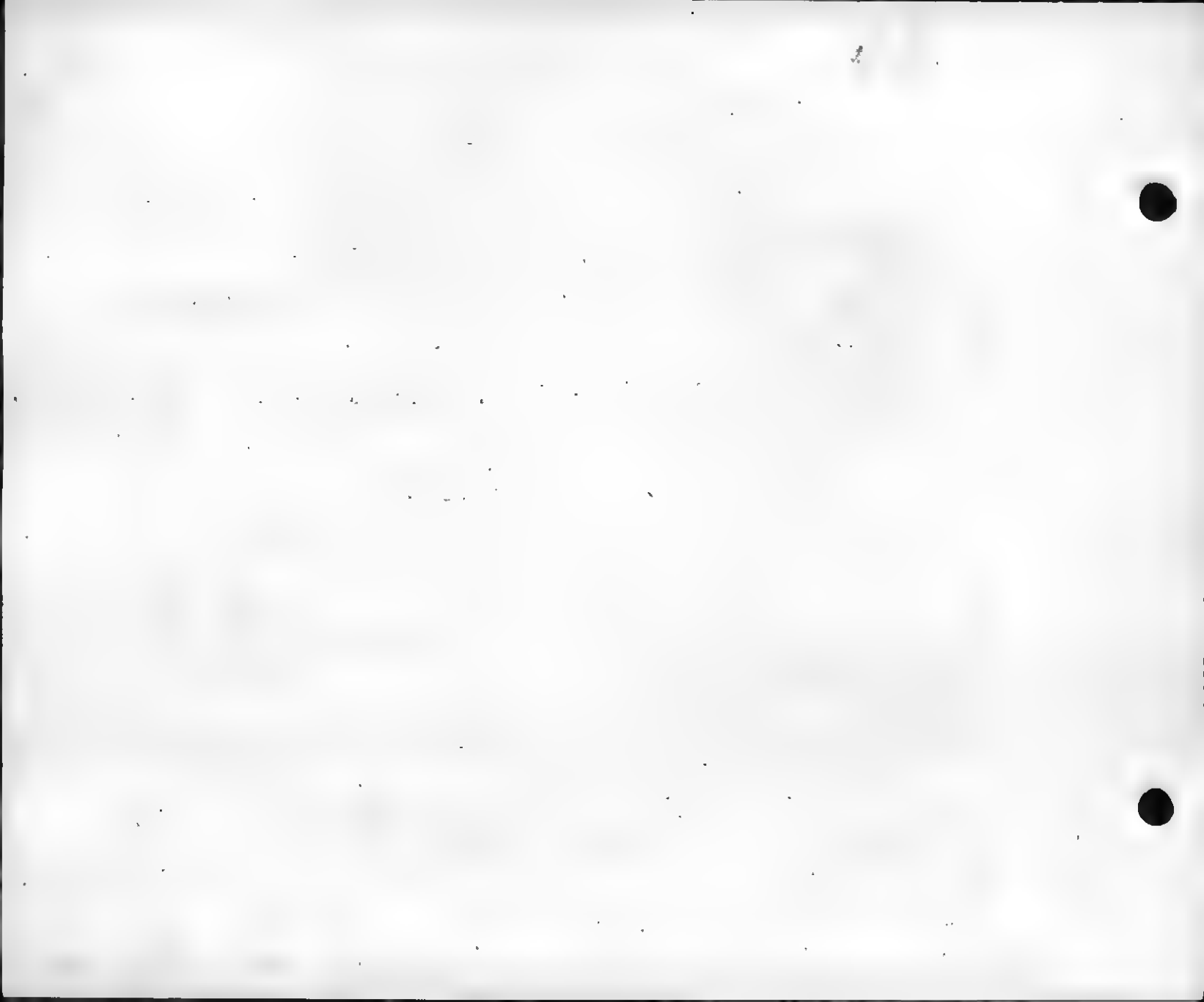


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Katharina</i> First <i>Becker</i> Middle Last		2a. DATE OF DEATH Month <i>4</i> Day <i>3</i> Year <i>68</i> 2b. HOUR <i>9:30</i> A M	
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>5-29-83</i>	6. AGE (In years last birthday) <i>84</i> YRS. <i>5</i> MONTHS <i>1</i> DAY
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Garrison</i> Baltimore Md
10. CITY OR TOWN OF DEATH <i>Garrison</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Fox High Care Center</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Own Home</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <i>George</i> Middle Last <i>Becker</i>		15. MOTHER'S MAIDEN NAME First <i>Emma</i> Middle Last <i>Boss</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>213-48-1509</i>	17. INFORMANT Address <i>Mr. Frederick Becker 5524 Robinwood Rd.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Vascular Accident</i> <i>1269</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>unknown</i>
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-4</i> , 19 <i>68</i> , to <i>4-3</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>4-2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>David S. Miller</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>4/3/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>David S. Miller</i>		22e. ADDRESS <i>9115 Reisterstown Rd.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/5/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore</i> <i>1-10</i>
24. FUNERAL DIRECTOR <i>J. I. Stansbury 6411 Windsor Mill Rd.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 5 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

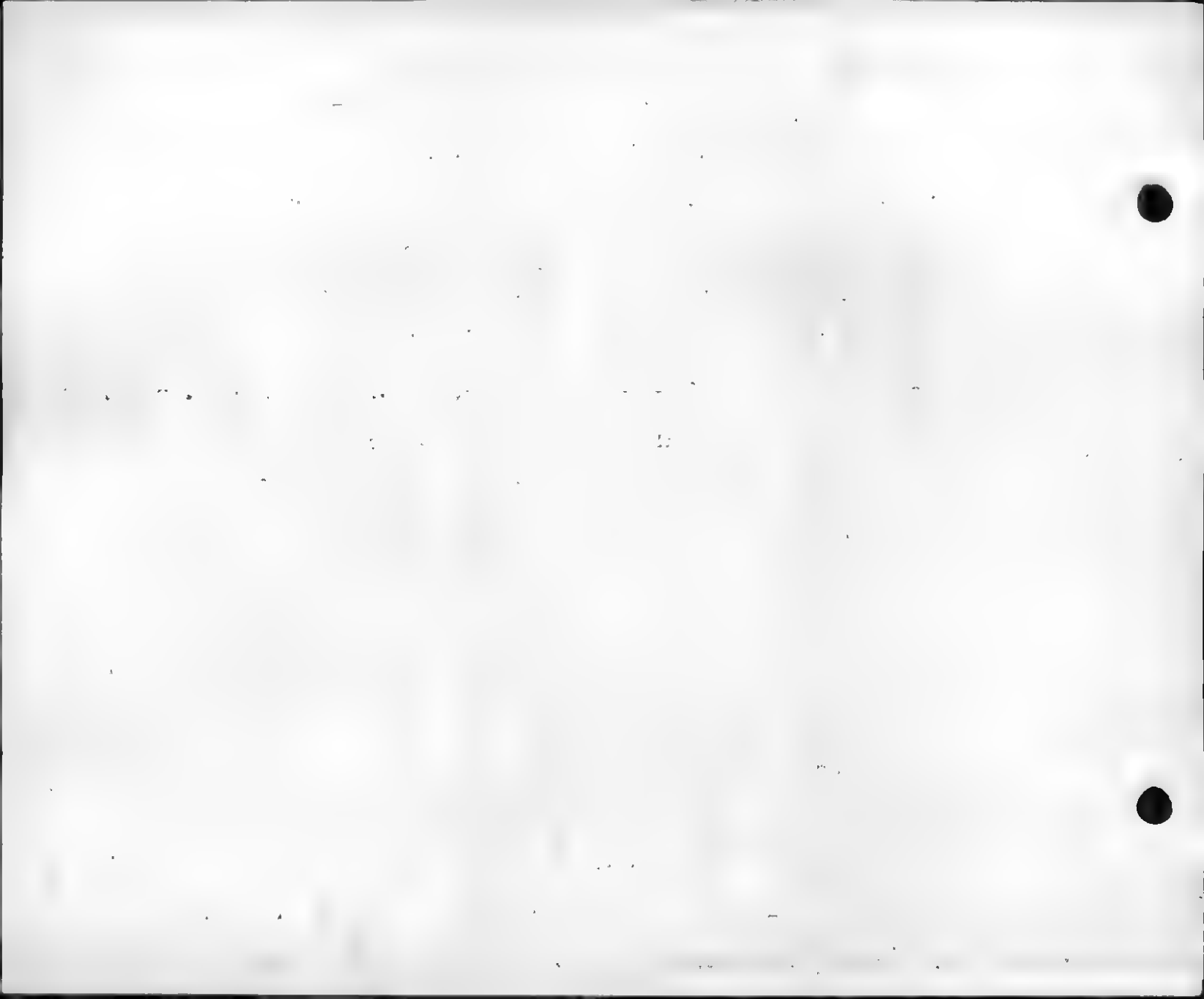
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05-20

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Rudolph August Bender		2a DATE OF DEATH 4-30-68 Month Day Year		2b. HOUR M
3 SEX M	4 RACE Cauc.	5. DATE OF BIRTH Sept. 13, 1882		6 AGE (In years last birthday) 85 YRS.
7a BIRTHPLACE (State or foreign country) Germany		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8204 Carrbridge Circle		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) (11)
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore	13c CITY OR TOWN Towson	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last August Bender		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth ?		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (If yes give war or dates of service) Unknown		16b SOCIAL SECURITY NO 284-03-6554A		17 INFORMANT Elizabeth A. Bleckaz, 8204 Carrbridge Circle
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES YEARS				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 3/15, 1967, to 4/30, 1968, that (I) (we) last saw the deceased alive on 3/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE Donald L. Somerville MD		22c. DATE SIGNED 5/1/68		22d PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE, M.D.
22e ADDRESS 25 W. PA. AVE TOWSON, MD 21204				
23a BURIAL, CREMATION, ETC. Burial		23b DATE 5-3-1968		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery
23d LOCATION (City or Town) (County) (State) Towson, Md. 21204				
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204		25a REC'D BY REGISTRAR DATE MAY 6 1968		25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

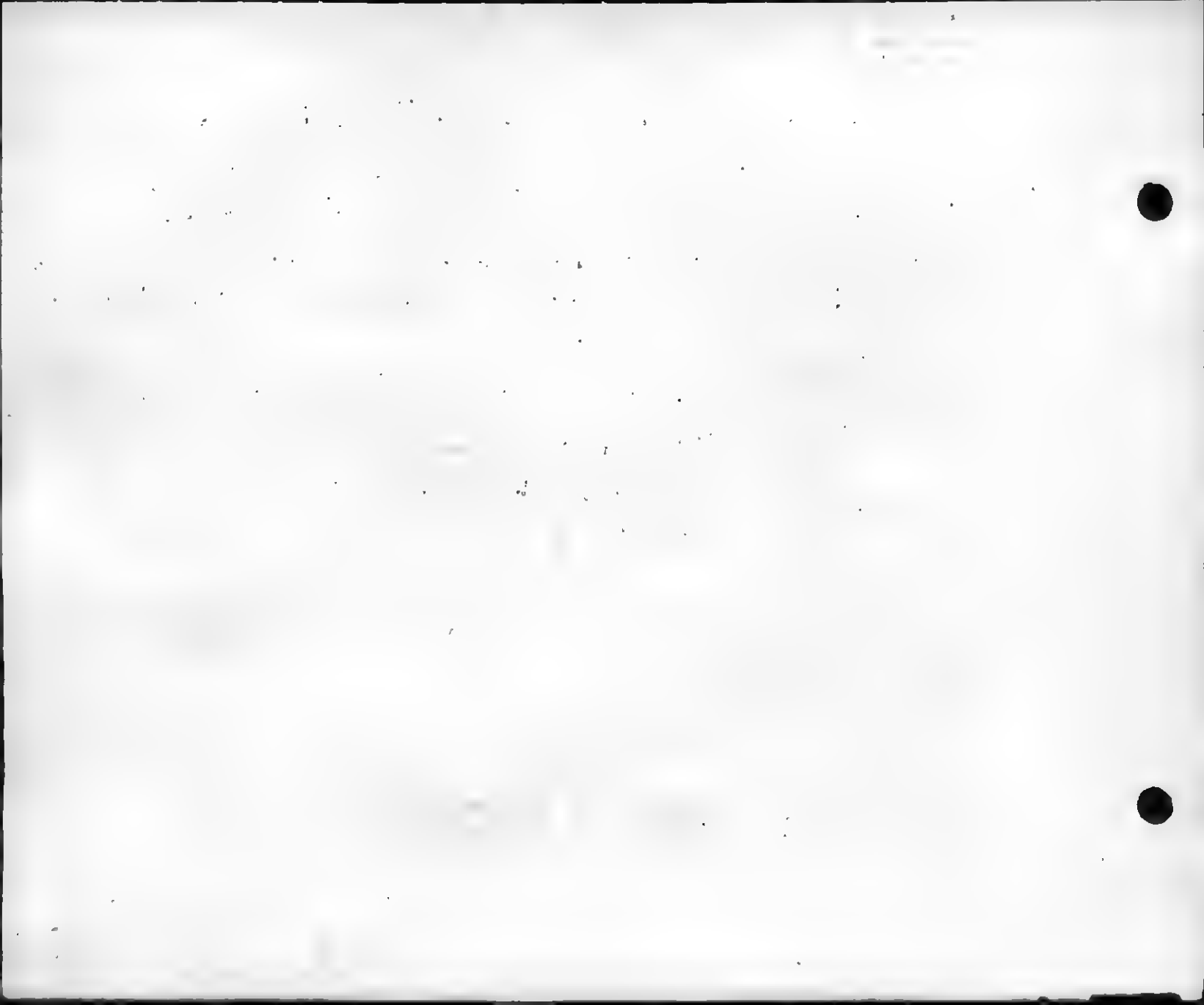
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (4)
30M REV 1/68

05181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Edward F Bennett			2a DATE OF DEATH Month Day Year April 28 1968			2b. HOUR 7 40 AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 3/7/98		6 AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) Lake City, Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County Gen Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cab Driver		12b KIND OF BUSINESS OR INDUSTRY Taxicabs	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Frank Bennett		15. MOTHER'S MAIDEN NAME First Middle Last ?		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			
16b SOCIAL SECURITY NO 216-07-1374		17. INFORMANT Mrs. Mary F. Bennett Address Baltimore 5202 Wilton Hgts Ave 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HACVD</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS Months YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 443X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sumner Call, MD				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/1/68		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION (City or Town) (County) (State) Wic.	
24. FUNERAL DIRECTOR Honing Byers				25a. REC'D BY REGISTRAR DATE MAY 1 1968		25b. REGISTRAR'S SIGNATURE Wm. J. Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

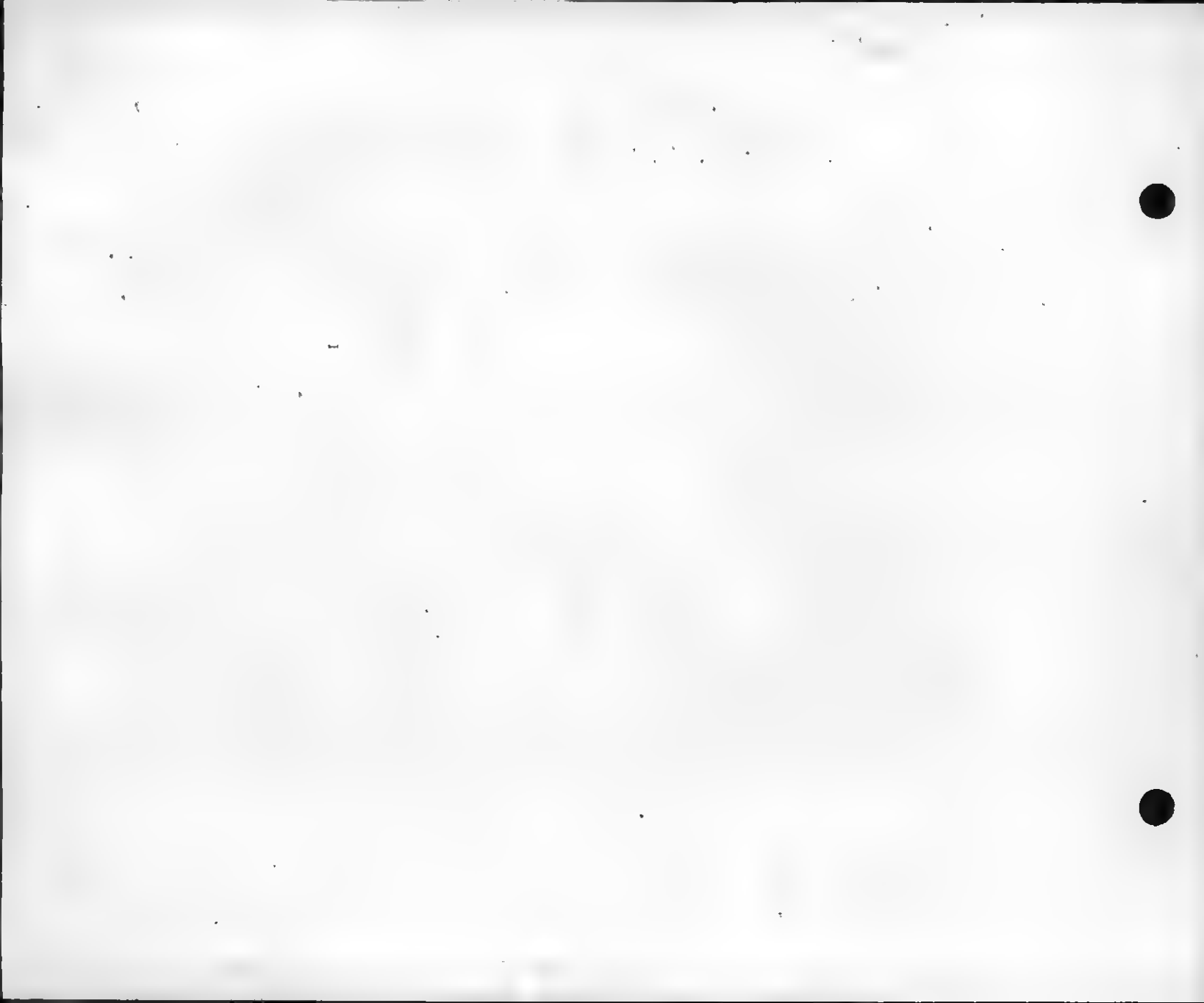
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05182

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) Henry J. Beran			2a. DATE KNOWN OF ESTIMATED DEATH <input checked="" type="checkbox"/> Month April Day 18 Year 1968			2b. HOUR 10:00 AM			
3 SEX Male	4 RACE White	5 DATE OF BIRTH June 8, 1912	6 AGE (In years last birthday) 55 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month April Day 18 Year 1968			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 954 Thompson Blvd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Welder		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 954 Thompson Blvd.	
14. FATHER'S NAME First Joseph Middle Beran Last Beran			15. MOTHER'S MAIDEN NAME First Julia Middle - Last -			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b. SOCIAL SECURITY NO 218 01 3826			17 INFORMANT Louise Beran			ADDRESS 2531 E. Ashland Avenue			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY 1129 IMMEDIATE CAUSE (a) A-S-C-V-Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE MELVIN B. DAVIS, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4-19-68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) 6800 MORNINGTON RD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE April 20, 1968			23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory			
24. FUNERAL DIRECTOR 1211 Chesaco Avenue			ADDRESS			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
25a. REC'D BY REGISTRAR APR 22 1968			25b. REGISTRAR'S SIGNATURE K. Charles Young			DATE			

MEDICAL CERTIFICATION



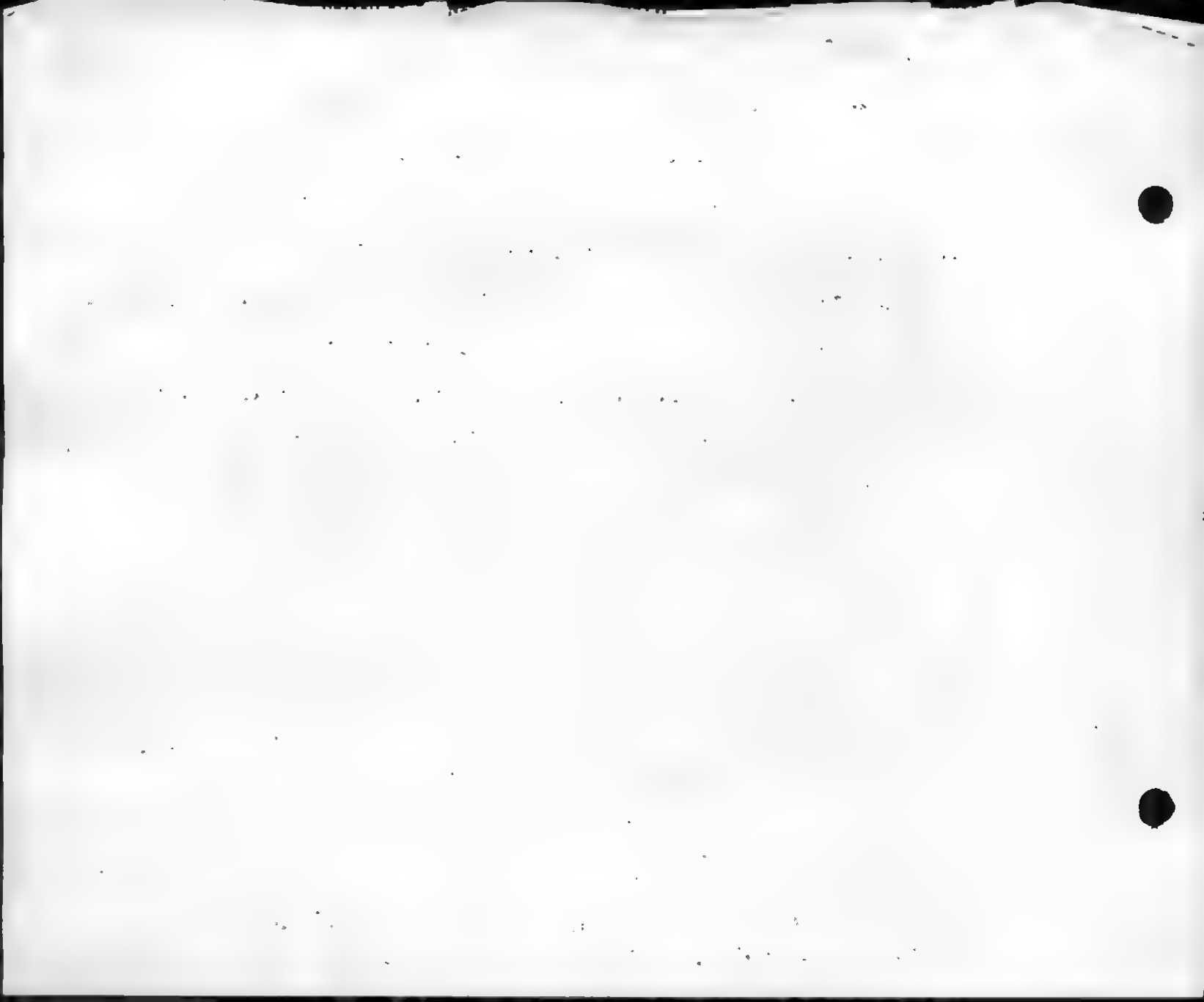
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

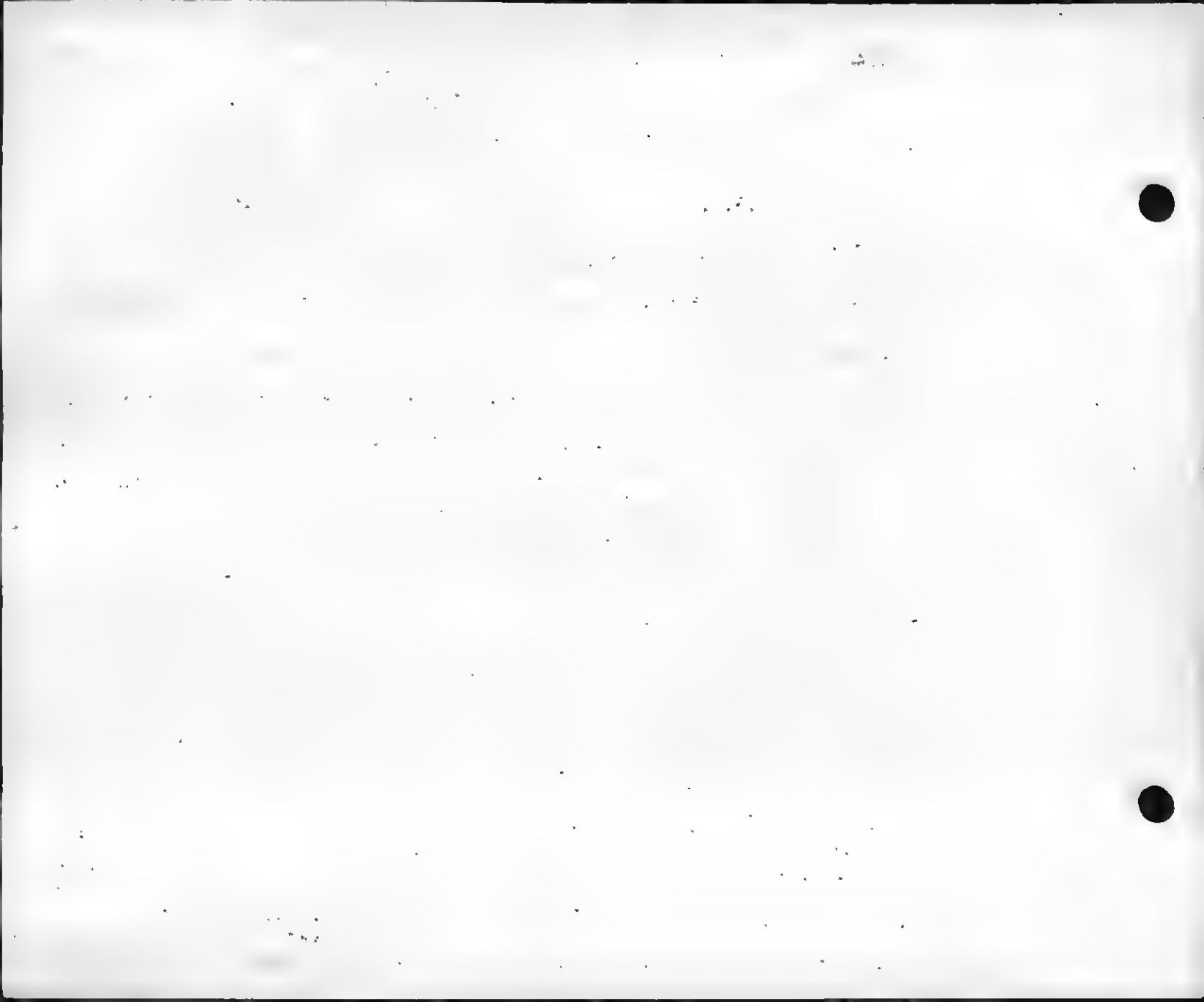
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Laura E. Bethke						April Month 9 Day 68 Year			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		July 25, 1887			80 YRS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			Summit Nursing Home			None			None
13a. USUAL RESIDENCE (Where deceased lived, if institution admission)			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland					Baltimore		402 N. Athol Ave.		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Louis Rever				Ella Francis Gibson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				212.07.9910		Nursing Home Records, Catonsville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS									5 min
4109 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
420.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec, 1968, to 4/9, 1968, that (I) (we) last saw the deceased alive on 4/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. C. Poyard MD								22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) J. C. Poyard								22e. ADDRESS 3325 Frederick Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/12/68		Lorraine Park		Baltimore, Baltimore Md.			
24. FUNERAL DIRECTOR J. T. Stensbury 6411 Windsor Mill Rd,				25a. RECEIVED BY REGISTRAR APR 15 1968		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

<div style="text-align: center;"> <p>35.84</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div>																				
1. DECEASED-NAME (Type or print)			First LEE			Middle A.			Last BINDSEIL			SR.			2a. DATE OF DEATH Month 4 Day 20 Year 1968			2b. HOUR 10 47 AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH Jan 1, 1886			6. AGE (in years last birthday) 82 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md								
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 1313 Stevens Avenue			21227					
14. FATHER'S NAME First Anton Middle Bindseil			15. MOTHER'S MAIDEN NAME First Bessie Middle Thomas			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Mr. Lee A. Bindseil, Jr.			Address 820 Seckel Cr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia 4129 DUE TO, OR AS A CONSEQUENCE OF CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Assoc'd (b) Assoc'd (c) Assoc'd												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 wks ?								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 4-20-68 to 4-20-68 , that (I) (we) last saw the deceased alive on 4-20-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE I. EARL PASS			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-20-68					
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS 4001 WILKENS AVE																	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-23-1968			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland											
24. FUNERAL DIRECTOR Howard H. Hubbard			ADDRESS 4107 Wilkens Ave.			25a. REC'D BY REGISTRAR DATE APR 22 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

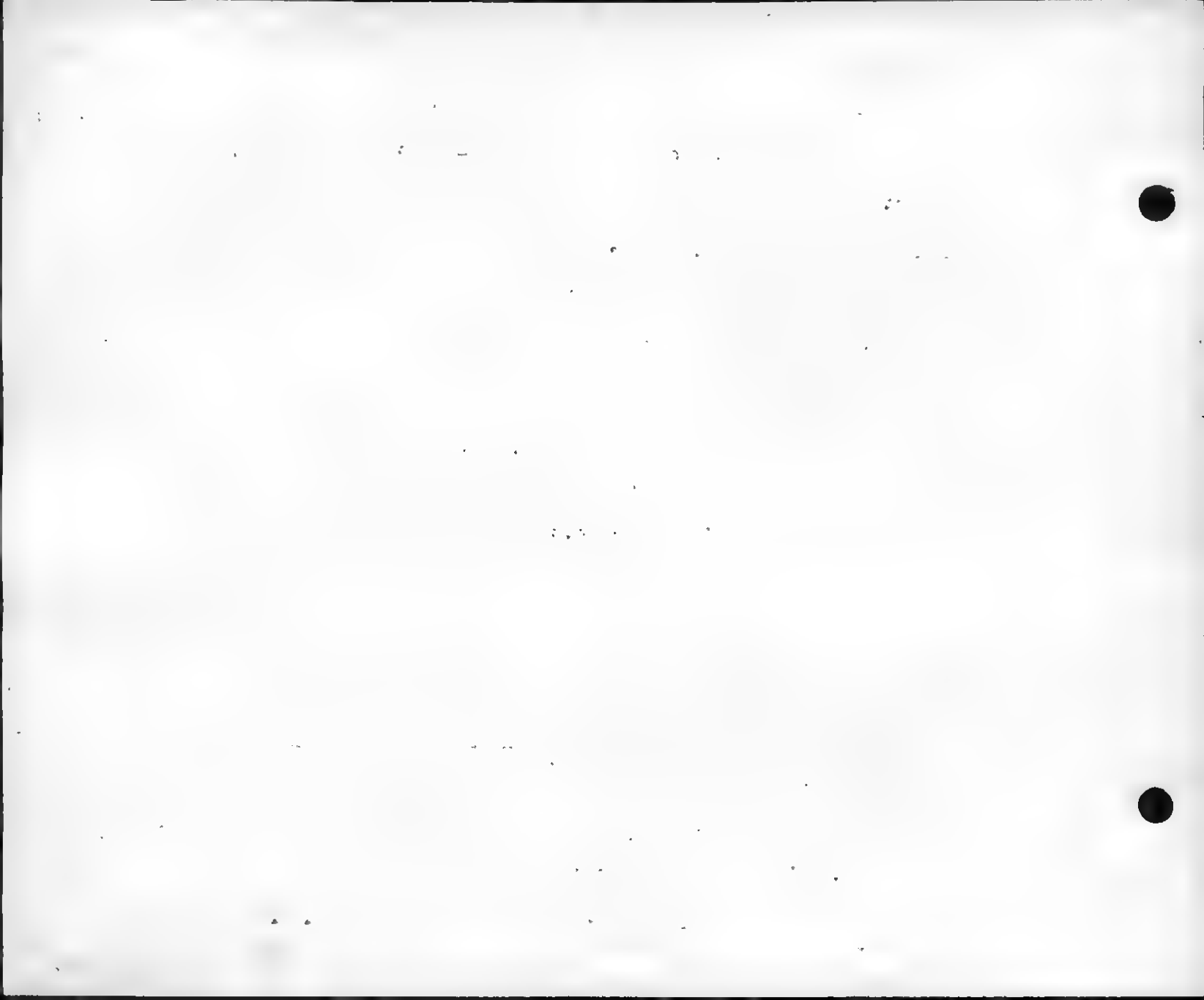
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

Item 18 Film #400 5-7-2
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Timothy		First		Middle		Last		2a. DATE OF DEATH Month 4 Day 8 Year 1968		2b. HOUR 1:25	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 6-24-1947		6 AGE (in years last birthday) 20 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Towson Md.					
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Towson		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 914 Fairway Drive			
14. FATHER'S NAME Warren		First		Middle		Last		15. MOTHER'S MAIDEN NAME Emilie		First Middle Last Burgemeister	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Warren Bittrick Address 914 Fairway Drive							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastro Intestinal Hemorrhage 536.9 DUE TO, OR AS A CONSEQUENCE OF Uremic Colitis (b) DUE TO, OR AS A CONSEQUENCE OF Lupus Nephritis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 57											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2-21- , 19 68 , to 4-8 , 19 68 , that (I) (we) last saw the deceased alive on 4-8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Lawrence Misanik M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-8-1968			
22d. PHYSICIAN'S NAME (Type) Dr. Lawrence Misanik M.D.						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or Town) Timonium, Md.		(County)		(State)	
24. FUNERAL DIRECTOR Ulrich Funeral Home						ADDRESS 4210 Belair Road.		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

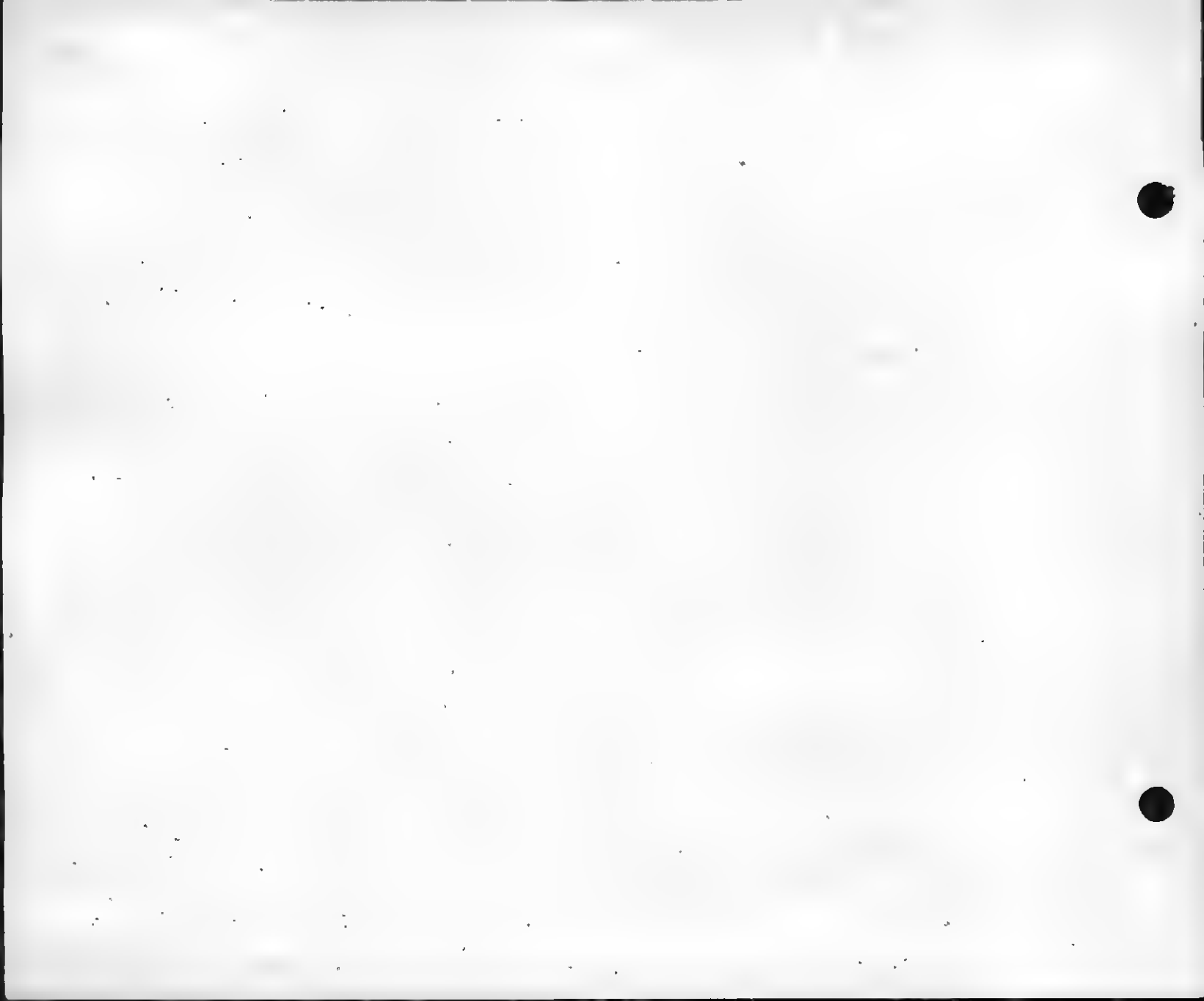
MD 410 (4-64)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05186

05190

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR A.M. P.M.	
William		H.	Blessing		April 2 1968		10:30 P.M.	
3 SEX	4. RACE	5 DATE OF BIRTH			6 AGE (In years lost birthday)	7c UNDER 18 YEARS MONTHS DAYS	7d UNDER 74 HRS HOURS MIN	
male	white	April 1, 1886			82 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Baltimore Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Dulaney Towson Nursing Home			salesman		Newport Good	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland		6		21207		3104 Ferndale Ave 21207 Md.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
George			Blessing		Katherine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
X		42-01-5367		Dulaney Towson Nursing Home		21204 West Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive Arterio Sclerosis</u> (b) <u>Indiscretions</u> DUE TO, OR AS A CONSEQUENCE OF <u>Indiscretions</u> (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)) <u>Senility</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1965</u> to <u>Apr 2, 1968</u> that (I) (we) last saw the deceased alive on <u>Apr 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
<u>M. Paul Byers</u>		4/2/68			M. Paul Byers			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			22f. DATE			
M. Paul Byers		5920 1/2 Rd Baltimore Md			APR 5 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR	
4-5-68			Wood Ridge		Baltimore Md		APR 5 1968	
24. FUNERAL DIRECTOR		24a. ADDRESS			24b. REGISTRAR'S SIGNATURE		24c. DATE	
<u>John J. Byers</u>		8728 1/2 Rd			<u>Charles Judge</u>		APR 5 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

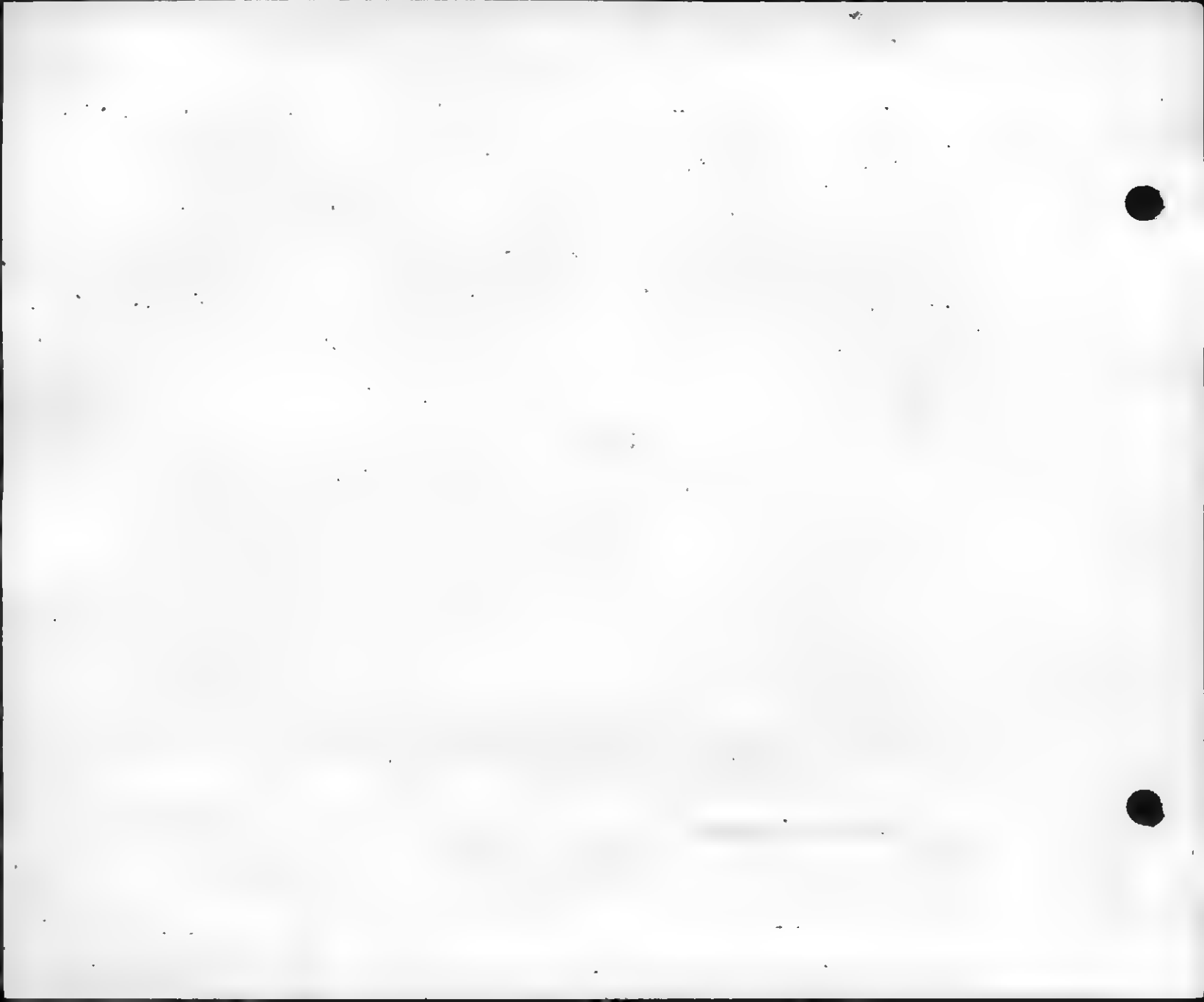
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10174
30M REV. 1/68

05187

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last ETHEL LUCRETIA BOUNDS			2a. DATE OF DEATH Month Day Year APRIL 3 1968		2b. HOUR MIN. 11 17
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH APRIL 15, 1883		6. AGE (in years last birthday) 84 YRS	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEDICAL CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND	13b. COUNTY BALTO.	13c. CITY OR TOWN TOWSON	13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7903 CID HARTFORD Rd.	
14. FATHER'S NAME First Middle Last GEORGE MARION	15. MOTHER'S MAIDEN NAME First Middle Last LOUISA COPPELAND				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 214 03 3723	17. INFORMANT Address EMERGENCY ADM. DEPT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>aspiration</u> 60 Y DUE TO, OR AS A CONSEQUENCE OF (b) <u>intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-3 1968, to 4-3 1968, that (I) (we) last saw the deceased alive on 4-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Liliana C. Baldonado	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 4/3/68			
22d. PHYSICIAN'S NAME (Type) LILIA C. BALDONADO	22e. ADDRESS B B M C				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-6-1968	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Baltimore, Md. Baltimore		
24. FUNERAL DIRECTOR Wm. COOK-PROCKTOWSON, Towson, Md.	25a. REGD BY REGISTRAR DATE APR 5 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



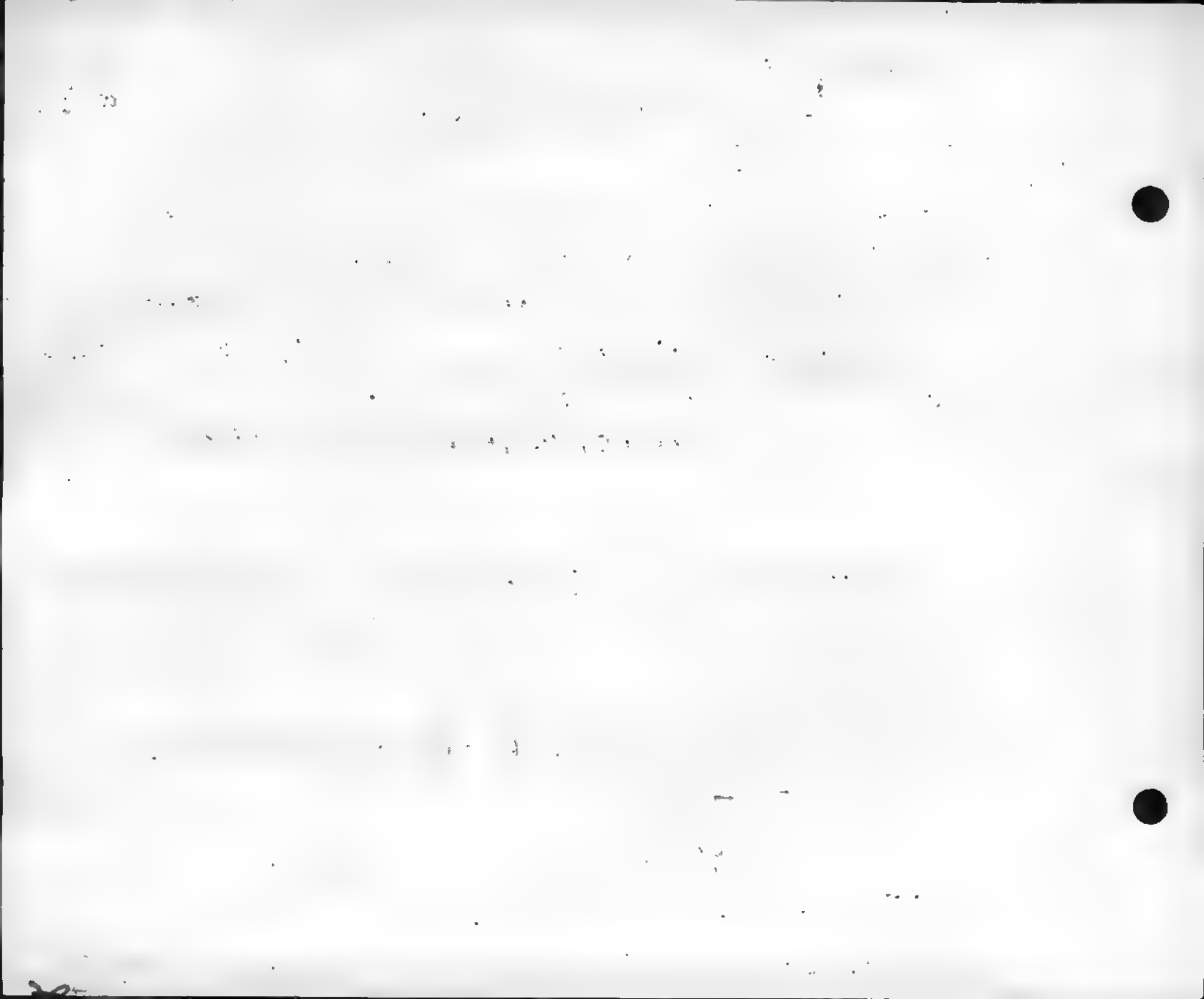
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
304 REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) Lottie May Bowen			2a. DATE OF DEATH Month 4 Day 19 Year 1968			2b. HOUR 12:05 AM				
3. SEX F		4. RACE Cau		5. DATE OF BIRTH 7-7-83		6. AGE (In years last birthday) 84 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md				
10. CITY OR TOWN OF DEATH Balto Co.			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GBMC			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MD			13b. COUNTY Balto		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 17 Brightside Ave.			
14. FATHER'S NAME First Charles Middle Marshall Last Disney			15. MOTHER'S MAIDEN NAME First Sarah Middle E Last Disney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-40-2057		17. INFORMANT Family					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DIABETIC ACIDOSIS - UREMIA 250.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF BLADDER WITH EXTENSION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from 4-16, 1968 to 4-19, 1968 , that (I) (we) last saw the deceased alive on 4-19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 86 oguelet		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-19-68				
22d. PHYSICIAN'S NAME (Type) CORUELET		22e. ADDRESS GBMC								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/22/68		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION (City or Town) (County) (State) PIRESVILLE BALTO MD				
24. FUNERAL DIRECTOR John S. Standing		ADDRESS 6411 Windsor Street		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE Charles Jones				

* APR 22 1968



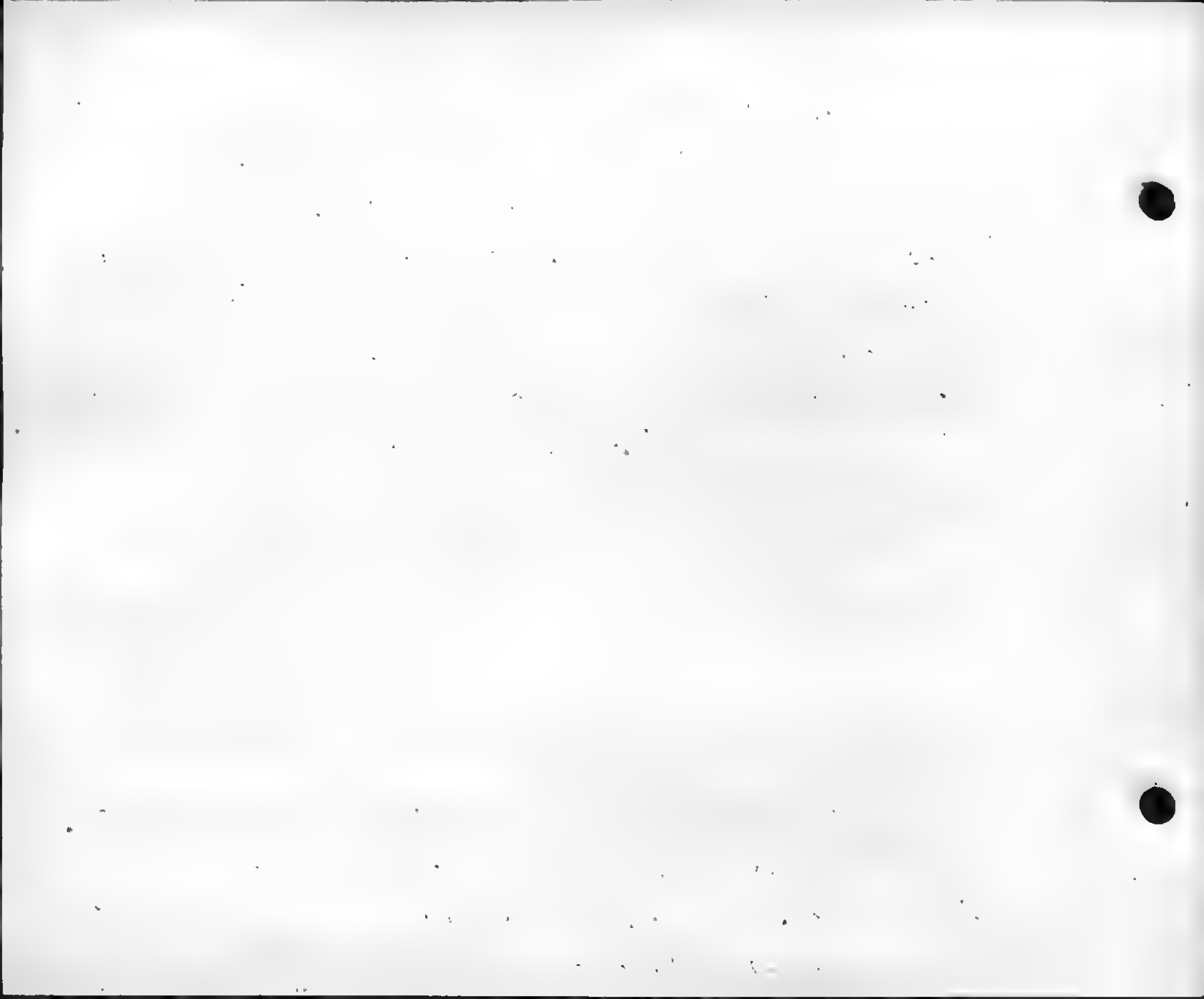
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Raymond J. Bowers</i>			2a. DATE OF DEATH Month <i>4</i> / Day <i>4</i> / Year <i>1968</i>			2b. HOUR <i>4 P.</i>			
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>12/15/96</i>		6 AGE (In years lost birthday) <i>71</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i>			
10 CITY OR TOWN OF DEATH <i>Towson</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St Joseph Hosp</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>guard</i>		12b. K NO OF BUSINESS OR INDUSTRY <i>maritime</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Towson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>3039 East Ave</i>	
14. FATHER'S NAME First Middle Last <i>UNKNOWN</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>WWI</i>		16b. SOCIAL SECURITY NO. <i>706-12-6015</i>		17. INFORMANT <i>Cordelia B. Towson</i>		Address <i>3039 East Ave</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY <i>4109</i> IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 HRS</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>no</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State <i>Appt 1, 55 4/4, 1968</i>					
22a I certify that (I) (this hospital) attended the deceased from <i>4/4/1968</i> to <i>4/4/1968</i> , that (I) (we) last saw the deceased alive on <i>4/4/1968</i> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above. (I) (we) (did) (and not) view the body after death.									
22b SIGNATURE <i>C. Mandelis</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR PHYS.		22c. DATE SIGNED <i>4/5/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Christopher Mandelis</i>		22e. ADDRESS <i>2308 Edmondson Ave.</i>							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b DATE <i>4/8/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Louisa National Cem</i>		23d LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>			
24 FUNERAL DIRECTOR <i>Ambrose Inc. 1328 Sulphur Sq. Rd.</i>		ADDRESS		25a REC'D BY REGISTRAR DATE <i>APR 5 - 1968</i>		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			



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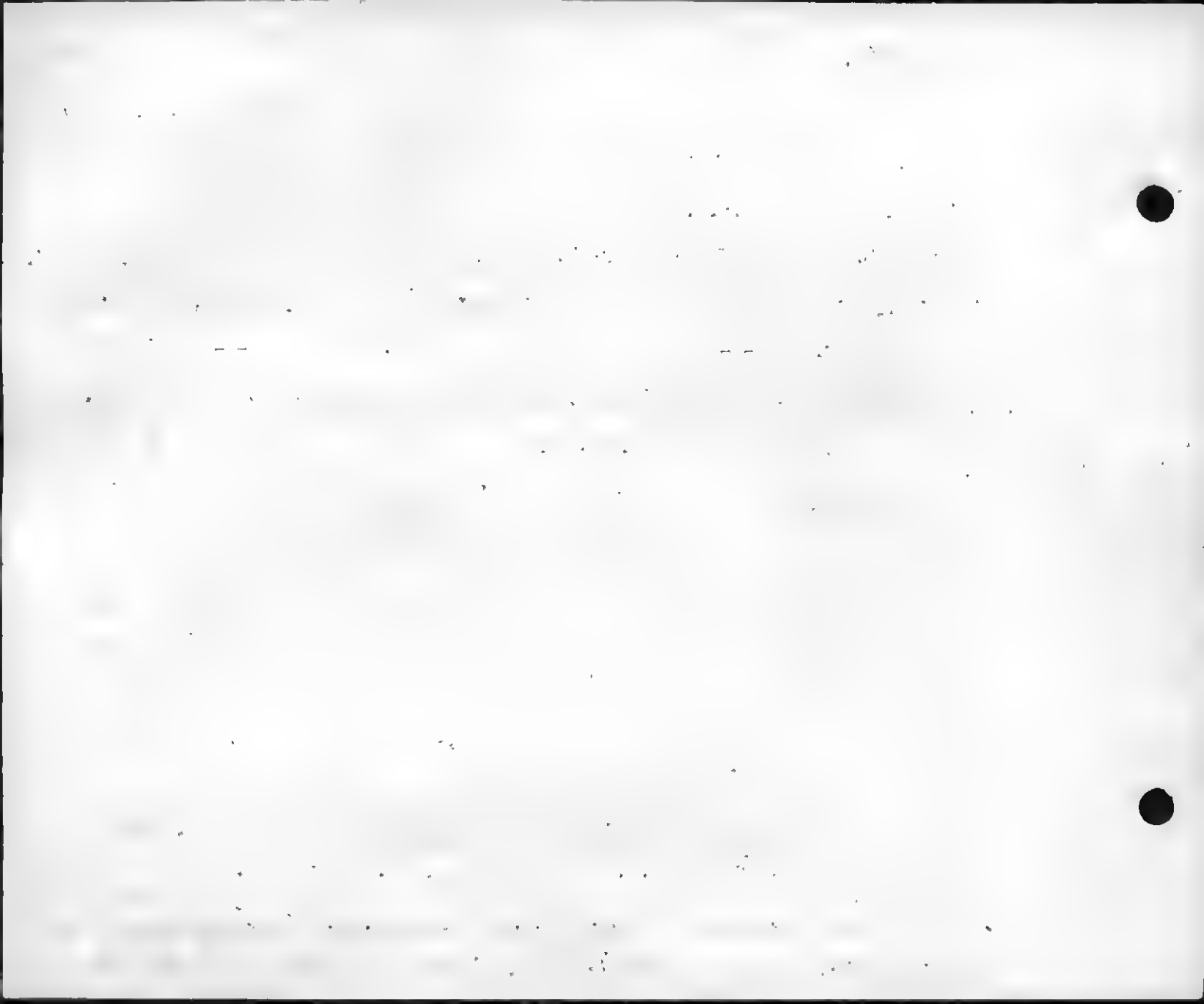
VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
DANIEL		EDWARD	BRATKOWSKI	APRIL 27, 1968		8:30A.M.		
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		2/2/24		44 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND	U.S.A.				BALTIMORE		FED. GOVERN.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VETERANS ADMIN. HOSPITAL		CLERICAL				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND				BALTIMORE				
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		13e. STREET AND NUMBER				
STANLEY - -		BRATKOWSKI		MARY - -		GUZINSKA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
YES WWII		216 18 98 55		CLINICAL RECORDS, VAH, FORT HOWARD, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:							DAYS	
IMMEDIATE CAUSE (a) HEPATIC COMA								
DUE TO, OR AS A CONSEQUENCE OF								
(b) CIRRHOSIS OF LIVER							YEARS	
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from APR 22, 1968, to APR 27, 1968, that (X) (we) last saw the deceased alive on APR 27, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		22c. DATE SIGNED		
MARIO J. QUIROS, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		4/27/68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
MARIO J. QUIROS, M.D.				VAH, FT. HOWARD, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		May 1 - 68		Balt. Nat. Cem		5500 Fred. Rd.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
FISHER FUNERAL HOME		1930 EASTERN AVE., BALTIMORE, MD.		MAY 1 1968		Charles Judge		

MEDICAL CERTIFICATION



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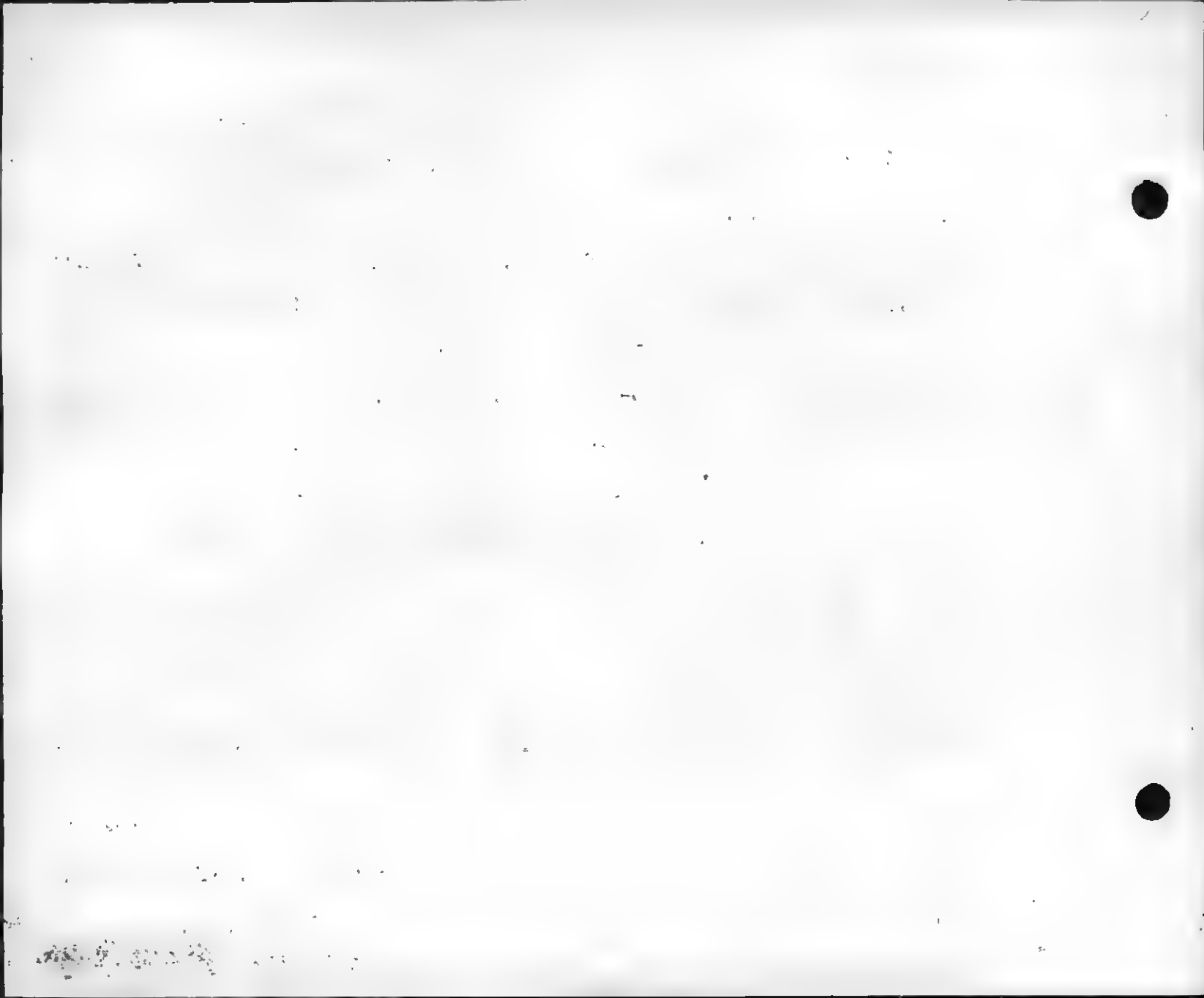
VR A15
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05-9A

05195

1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR H M				
EDNA J. BREYER								APRIL 12 1968			11 30 A. M.				
3 SEX	4. RACE	5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS M.M.					
FEMALE	WHITE	FEBRUARY 19 1884				84 YRS.									
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md							
MARYLAND	U.S.A.			BALTIMORE											
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY										
RODGERS FORGE	218 OVERBROOK RD.		SALES LADY		DEPT. STORE										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER									
MARYLAND	BALTIMORE					218 OVERBROOK RD.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S M.A.DEN NAME		First		Middle		Last	
						HORNEY								UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address							
NO				214-26-9387		MR. EDMUND G. BETZ		SAME							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio - Respiratory Failure</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hodgkins Disease - Generalized</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive - Arteriosclerotic CVA</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 7, 1949</u> to <u>Apr 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Apr 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED							
<u>Willard Applefeld</u>								4/13/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS													
WILLARD APPLEFELD		6615 REISTERSTOWN RD. BALTIMORE, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
BURIAL		4/15/68		LOUDON PARK		BALTIMORE, MD.									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
MITCHELL WIEDEFELD HOME, INC.				DATE		APR 16 1968		<u>Charles Judge</u>							
6500 YORK RD. BALTIMORE, MD.															



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<div>05-92</div> <div> <div>1</div> <div>MD</div> </div> <div> <div>1</div> <div>MD</div> </div>																	
<div> <div>MD</div> <div>05-92</div> </div> <div> <div>1</div> <div>MD</div> </div>																	
<div> <div>1</div> <div>MD</div> </div> <div> <div>1</div> <div>MD</div> </div>																	
1 DECEASED-NAME (Type or print)			First Grace			Middle May			Last Brown			2a DATE OF DEATH Month April Day 23 Year 1968			2b HOUR a:20 m		
3 SEX female			4 RACE white			5 DATE OF BIRTH Sept. 23, 1892			6 AGE (In years last birthday) 75 YRS			7 UNDER 1 YEAR MONTHS DAYS			8 UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Md.			7b CITIZEN OF WHAT COUNTRY? U. S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md								
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b KIND OF BUSINESS OR INDUSTRY								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Balto.			13c CITY OR TOWN Balto.			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 1527 W. Lombard St.					
14 FATHER'S NAME First Joseph Kidd			Middle Last			15. MOTHER'S MAIDEN NAME First Mary E. Stupp			Middle Last Stupp								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b SOCIAL SECURITY NO. NONE			17 INFORMANT Records: SPRING GROVE STATE HOSPITAL						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death 4-1-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. 4-2-77 (b) Atherosclerotic Cardiovascular Ht. Dis. 20 years DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, senile 20 years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Mitral Stenosis with atrial fibrillation, 20 years or more.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory office building etc.)			21f LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (X) (this hospital) attended the deceased from Nov. 5, 1937, to April 23, 1968, that (X) (we) last saw the deceased alive on April 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.																	
22b SIGNATURE Anthony J. Young, M.D.			22c DATE SIGNED 4-23-68			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE Apr. 26-1968			23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d LOCATION (City or Town) (County) (State) Frederick, Md. 21701								
24 FUNERAL DIRECTOR R.W. Keweenaw M.R. Etchison			25a. DATE BY REGISTRAR APR 26 1968			25b REGISTRAR'S SIGNATURE Charles Judge											



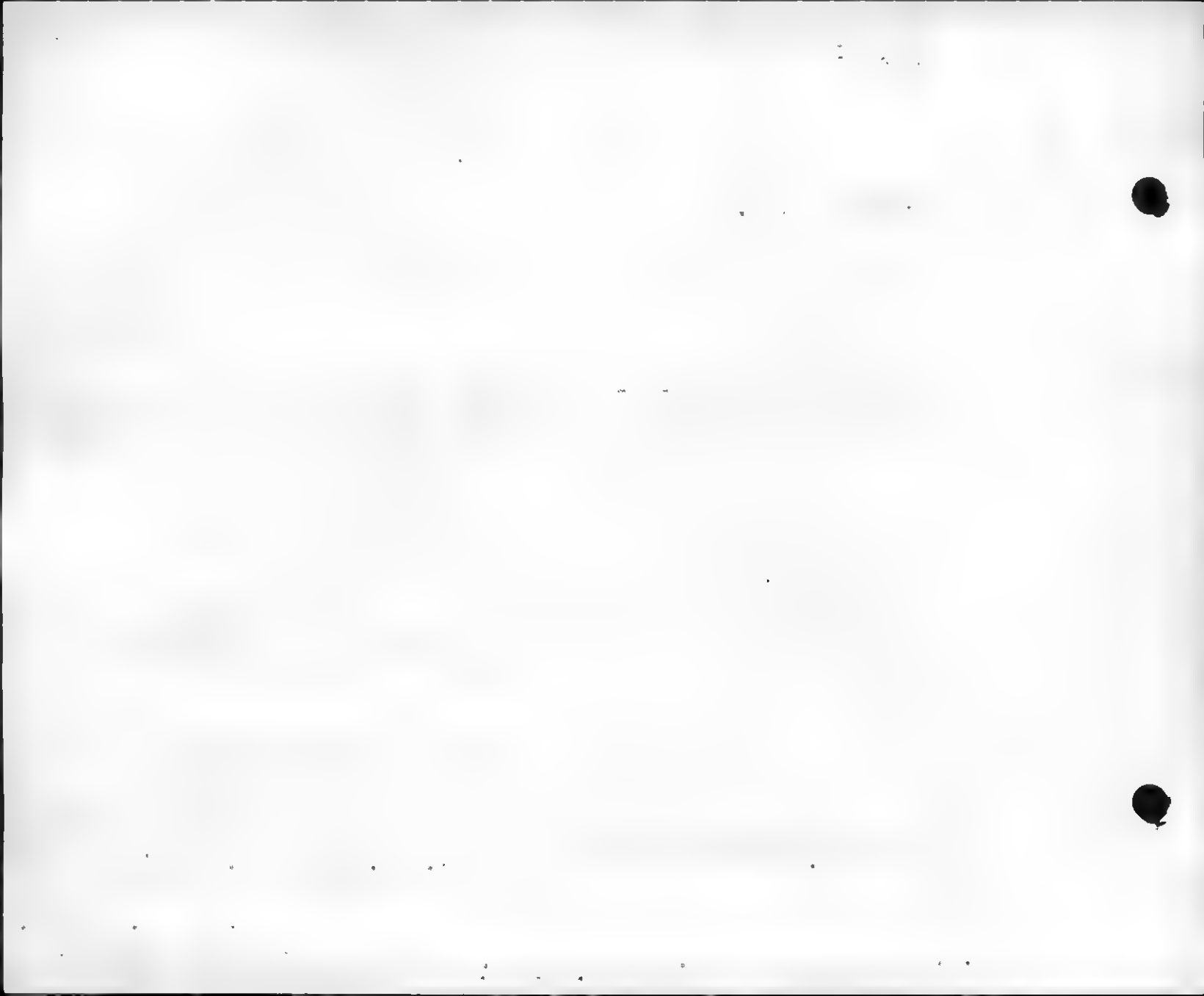
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VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Rhoda Chairs Brown			2a. DATE OF DEATH Month April Day 23 Year 1968			2b. HOUR A.M. 9:50 M					
3 SEX female		4. RACE white		5 DATE OF BIRTH Sept. 11, 1895		6 AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0			
7a BIRTHPLACE (State or foreign country) AnneArundelCty., Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Towson, Maryland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Towson Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Timonium		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1912 Pot Spring Road		
14 FATHER'S NAME First Samuel Middle Chairs Last Brown			15 MOTHER'S MAIDEN NAME First Annie Middle Linsted Last Brown			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 212-28-7851		
17a INFORMANT Dulaney Towson Nursing Home, 111 West Road			17b ADDRESS 21204			18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Hypertensive vascular dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 44-3x (b) — DUE TO, OR AS A CONSEQUENCE OF — (c) — PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Peripheral neuropathy of leg.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR A.M. — Month — Day — Year 19 P.M. —			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) —			21d INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —			21f LOCATION Street or R.F.D. No. — City or Town — County — State —			22a I certify that (I) (this hospital) attended the deceased from Jan 19 1968 to April 23 1968 , that (I) (we) last saw the deceased alive on 4/23 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.			22b SIGNATURE Dr. Christian Mass		
22c DATE SIGNED 4/24/68			22d PHYSICIAN'S NAME (Type) Dr. Christian Mass			22e ADDRESS Balto. Nat. Pike & St. Johns' Lane			22f DEGREE —		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 4/26/68			23c NAME OF CEMETERY OR CREMATORY Woodlawn			23d LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.		
24 FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			24a ADDRESS 1905 York Rd. Balto. 12, Md.			25a REC'D BY REGISTRAR DATE APR 25 1968			25b REGISTRAR'S SIGNATURE J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

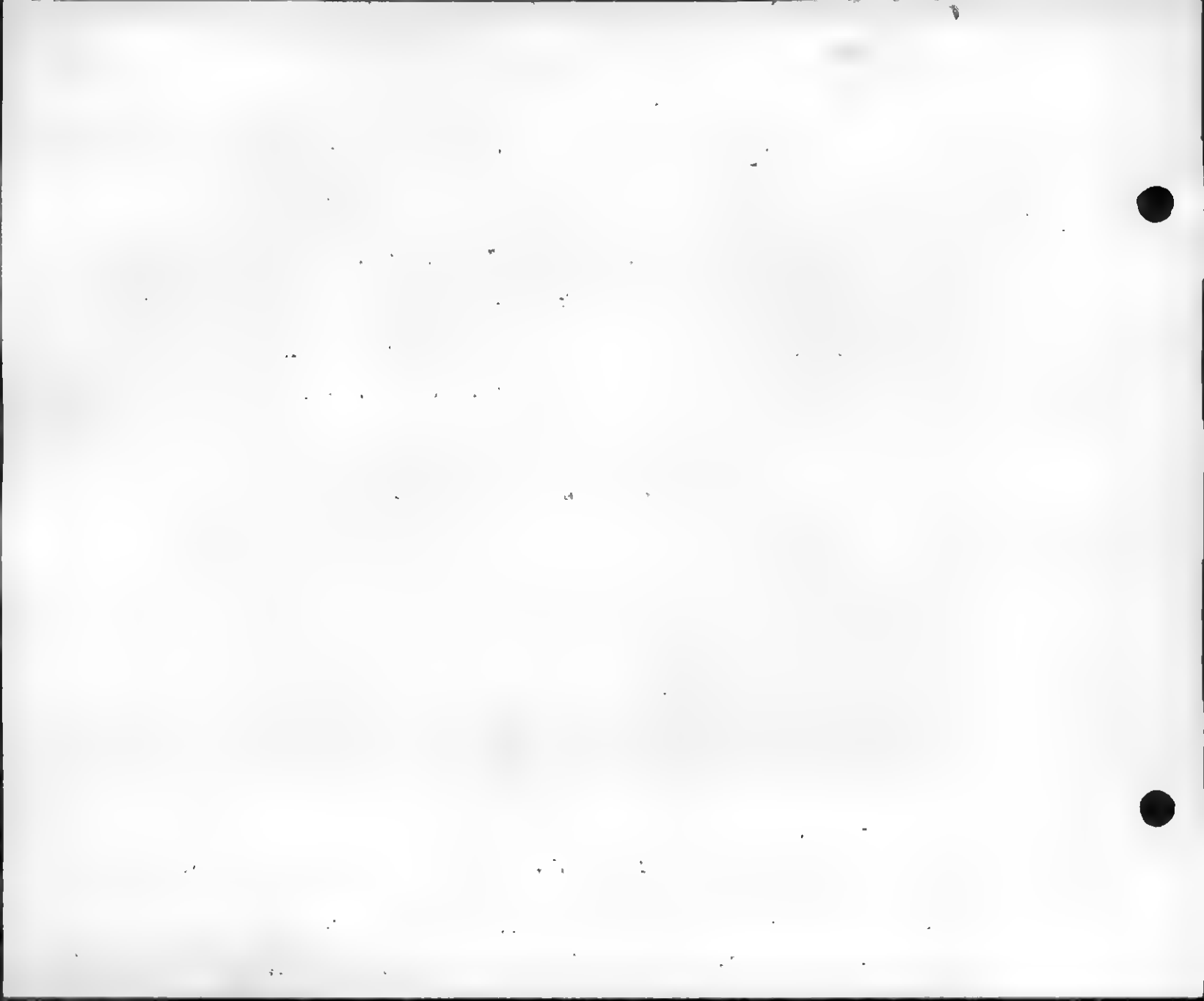
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Charles		First S	Middle C A R O	Last	2a DATE OF DEATH Month April Day 24 , Year 1968	2b HOUR 2:45 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH January 1, 1895		6 AGE (In years last birthday) 73 YRS	7 UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore,		Md.	
10. CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) tailor		12b KIND OF BUSINESS OR INDUSTRY Tailoring	
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 2823 Harview Ave.		
14. FATHER'S NAME First John Middle Caro		15. MOTHER'S MAIDEN NAME First Catherine Middle Bianca		Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Rose D. Caro- Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intestinal Infarction 444 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) Thrombosis of superior mesenteric artery DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recurrent Myocardial Infarction						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (this hospital) attended the deceased from 4/8/ , 19 68 , to 4/24/ , 19 68 , that (I) (we) last saw the deceased alive on 4/24/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Reynaldo Orjuela Gomez, M.D.						22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/29/68	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.		ADDRESS		25a. REC'D BY REG. STRAR DATE APR 25 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATE ON

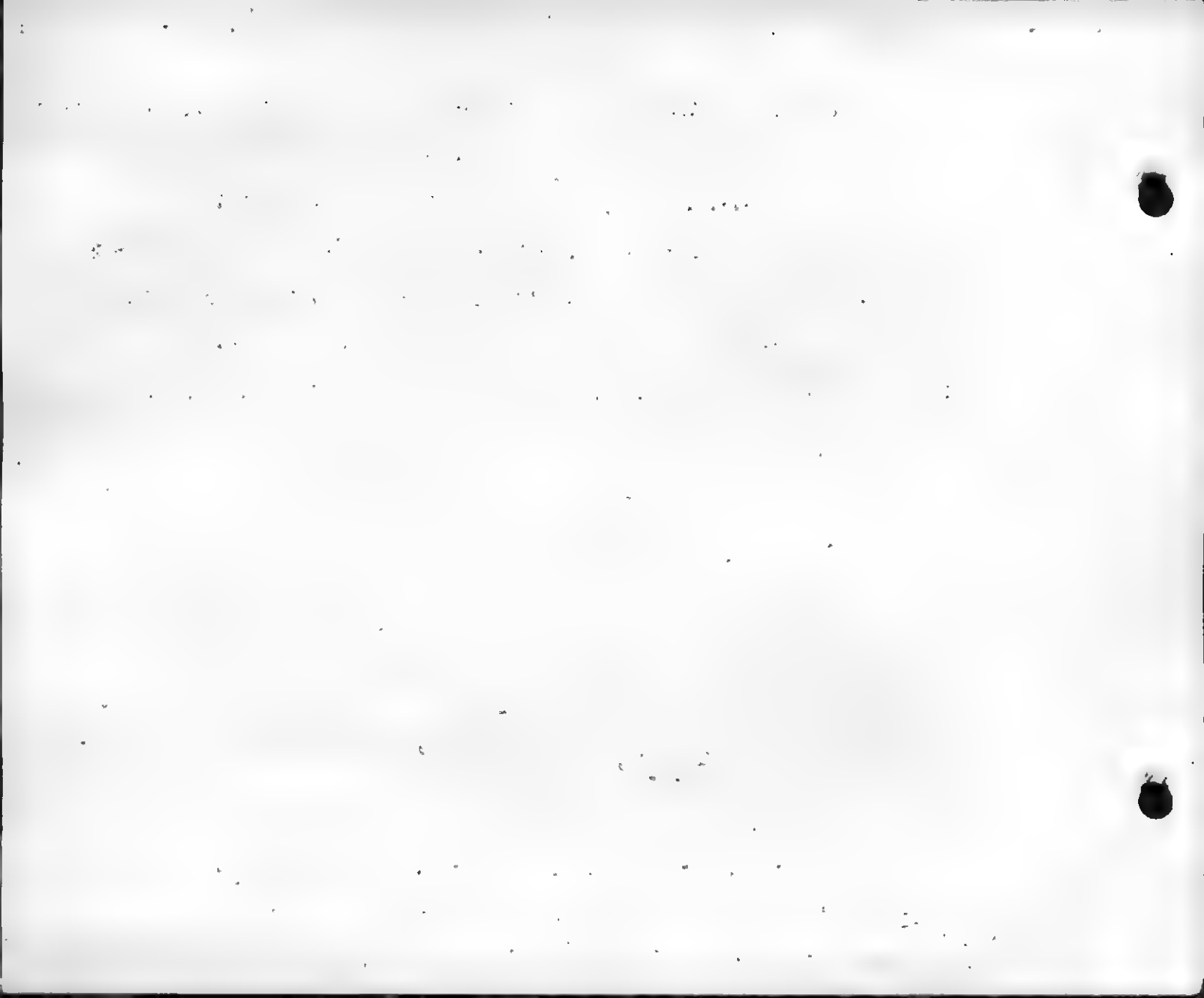


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-75 (4)
30M REV 1-68

05195										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05199																																							
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
JEROME FRANCIS CARTER										APRIL 20, 1968										1:30A M																																							
3 SEX MALE										4 RACE WHITE										5 DATE OF BIRTH 10/8/95										6 AGE (In years last birthday) 72 YRS										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Md.																													
10 CITY OR TOWN OF DEATH FORT HOWARD										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MECHANIC										12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY BALTIMORE										13c. CITY OR TOWN BALTIMORE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 710 PURITAN STREET																			
14. FATHER'S NAME First Middle Last JEROME FRANCIS CARTER										15. MOTHER'S MAIDEN NAME First Middle Last KATHERINE M. SIDE										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES										16b. SOCIAL SECURITY NO. 217 12 07 20										17 INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
4129										IMMEDIATE CAUSE (a) Congestive Heart Failure										Recent																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease										Unknown																																							
										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (s) (this hospital) attended the deceased from APRIL 12, 1968, to APRIL 20 1968, that (s) (we) last saw the deceased alive on APRIL 20, 1968, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Isabelita Y. Cordoba M.D.										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 4 20 68																																							
22d. PHYSICIAN'S NAME (Type) ISABELITA Y. CORDOBA, M. D.										22e. ADDRESS VAH, FORT HOWARD, MD.																																																	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL										23b. DATE April 23, 1968										23c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY										23d. LOCATION (City or Town) (County) (State) Towson, Maryland																													
24. FUNERAL DIRECTOR W.M. COOK										Towson										25a. REC'D BY REGISTRAR, DATE APR 23 1968										25b. REGISTRAR'S SIGNATURE Charles J. J...																													
BROOKS FUNERAL SERVICE										1050 YORK RD. BALTIMORE 04, MD																																																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-4 and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 4-96

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>AGNES</i> First <i>REBECCA</i> Middle <i>CARVER</i> Last						2a. DATE OF DEATH Month <i>4</i> Day <i>12</i> Year <i>68</i>			2b. HOUR <i>6:40 PM</i>			
3. SEX <i>F</i>		4. RACE <i>CAU.</i>		5. DATE OF BIRTH <i>6-15-90</i>			6. AGE (In years lost birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS <i>77</i> DAYS <i>77</i>		IF UNDER 24 HRS. HOURS <i>77</i> MIN <i>77</i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTO.</i> <i>TOWSON</i> Md.						
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>GREATER BALTIMORE MEDICAL CENTER</i>				12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>MD</i>				13b. COUNTY <i>BALTO.</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>10815 REISTERSTOWN ROAD</i>		
14. FATHER'S NAME First <i>Cornelius</i> Middle <i>Baumbitz</i> Last <i>BAUMBITZ</i>				15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i>G-111</i> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>UNKNOWN</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <i>213-50-6026</i>		17. INFORMANT <i>PATIENTS CHART</i> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Embolism.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>a few minutes</i> <i>a few minutes</i> <i>several days</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>subcutaneous obstruction, myocardial ischemia</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>4</i> Day <i>12</i> Year <i>68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>4-8</i>		City or Town <i>1968</i>		County <i>to 4-12</i>		State <i>198</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>4-8</i> , 19 <i>68</i> , to <i>4-12</i> , 19 <i>8</i> , that (I) (we) last saw the deceased alive on <i>4-12</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Collado</i>						DEGREE <i>ATTENDING PHYS.</i> <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4-12-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>A. Collado, M.D.</i>						22e. ADDRESS <i>6701 NORTH CHARLES ST</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>April 15, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Carrolls Chapel Cem.</i>		23d. LOCATION (City or Town) <i>Balto. County, Md.</i>		(County) (State)				
24. FUNERAL DIRECTOR <i>H.J. Schhardt</i>				ADDRESS <i>Owings Mills, Md.</i>		25a. REC'D BY REGISTRAR <i>APR 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

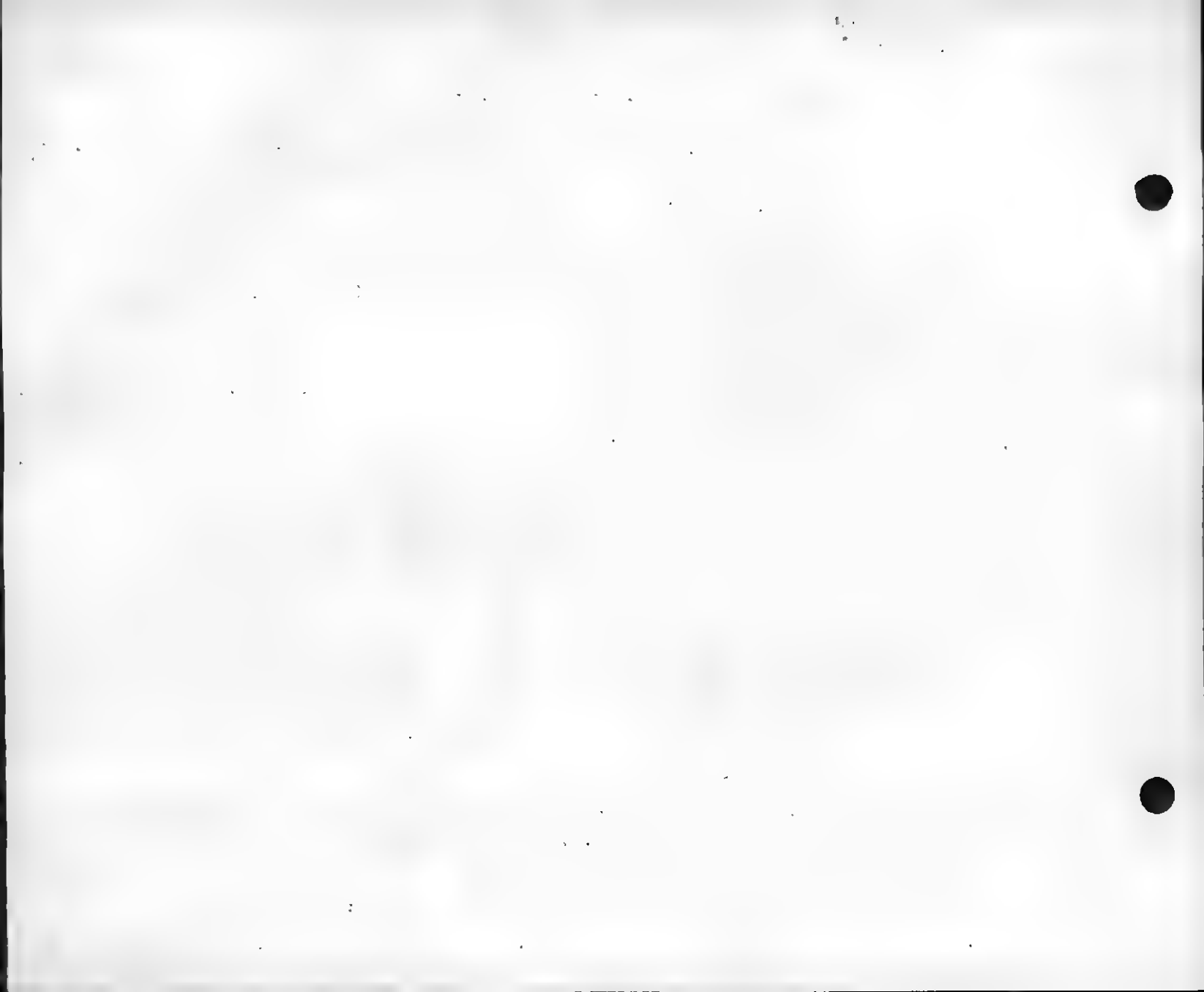


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

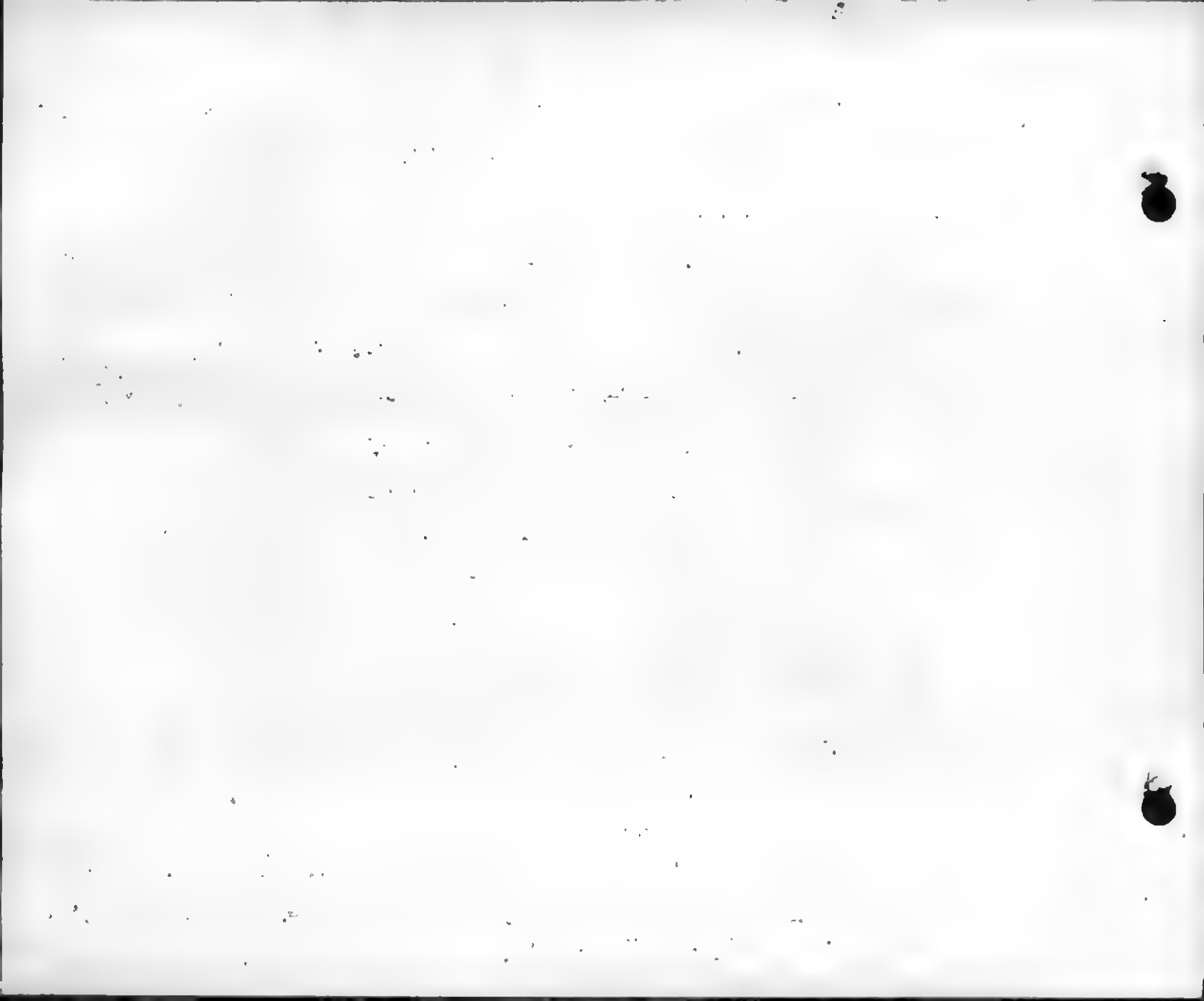
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF ESTABLISHED DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>	
VIRGINIA			IRENE		CASS				Month Day Year 19 68	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	7 UNDER 1 YEAR DAYS	7 UNDER 24 HRS HOURS	7 UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD		2d HOUR
Female	White	4-19-1965	3 YRS					Month April Day 25 Year 19 68		8:00 AM
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Chicago Hgts., Ill.			USA		BALTIMORE					
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			2c. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Lutherville			1005 Adcock Road							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Baltimore		Lutherville				1005 Adcock Road	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Wade			Cass		Carol		Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
No			Never Had one		Wade Cass		1005 Adcock Rd., Lutherville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Epilepsy</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
3535										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			Charles S. Springate, M.D.				22b. DATE SIGNED		April 25, 1968	
EXAMINER'S NAME (Type)			Charles S. Springate, M.D.				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			4-27-1968		Lakewood Park Cem.		Westlake, Ohio			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks, Towson, Inc. Towson, Md.						DATE		APR 29 1968		



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

3519A										MAY 1968										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05202																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																																							
George										W. Champness										Month Day Year										April 13 68										6.15PM																													
3 SEX										4 RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										7. UNDER 1 YEAR										IF UNDER 24 HRS																			
Male										White										4-7-1886										82										MONTHS DAYS HOURS MIN.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																							
Maryland										U.S.A.																				Baltimore																				Md																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																																							
Towson										St. Joseph Hospital										Retired										Insurance																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																													
Maryland																				Baltimore										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1423 Montpelier Street																													
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																																							
Thomas W. Champness																				Mary Lewald																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO										17. INFORMANT										2208 Florimond Ave. Michigan City, Ind. 46360																																							
No										212-09-4021A										Kennard F. Champness																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										4109										infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
																				DUE TO, OR AS A CONSEQUENCE OF										Arteriosclerotic Cardio-vascular disease.																																							
																				DUE TO, OR AS A CONSEQUENCE OF										Cerebral vascular thrombosis																																							
																				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																							
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																	
										HOUR A.M. Month Day Year																																																											
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No										City or Town										County										State									
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>																																																																					
22a. I certify that (this hospital) attended the deceased from 4/4/1968, to 4/13/1968, that (we) saw the deceased alive on 4/13/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.																																																																					
22b. SIGNATURE										22c. DATE SIGNED																																																											
										4-14-68																																																											
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																											
Samuel Lee, M.D.										7620 York Rd., Towson, Md., 21204																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																							
Burial										4-17-68										Holy Redeemer Cemetery										4430 Belair Rd., Balto., Md.																																							
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Charles J. Gyles										901 S. Conowingo St. Baltimore, 21224, Md.										APR 18 1968										Charles J. Gyles																																							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item #21, File #198
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR
DONALD				CHAPPLE JR	19		M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years MONTHS DAYS YRS)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	Negro	Jan 27-67	15			April 24 1968	9:30 PM
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10b. KIND OF BUSINESS OR INDUSTRY	
Baltimore Md	USA			BALTIMORE			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto	St. Joseph Hospital						
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Md.		Baltimore		716 Mc Cabe Avenue			
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last
Donald Chappel Sr				Cecelyn Chappel			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO	17. INFORMANT		ADDRESS			
No		Donald Chappel Sr					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 890X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } Carbon monoxide DUE TO, OR AS A CONSEQUENCE OF Conflagration							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20 EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21 TIME OF INJURY Month, Day, Year HOUSING 8:55 PM 4-24 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) Undetermined			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f LOCATION Street or RFD No		City or Town	County	State
			716 Mc Cabe Ave.		Baltimore		Md.
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED April 25, 1968	
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town)		County	State
Burial	4-27-68	Mt Auburn Cmt		Baltimore Md			
24 FUNERAL DIRECTOR	ADDRESS			25a REC'D BY REG STRAR	25b REG STRAR'S SIGNATURE		
William-Cook, Brooks, York Road, Towson, Md.				DATE APR 26 1968			

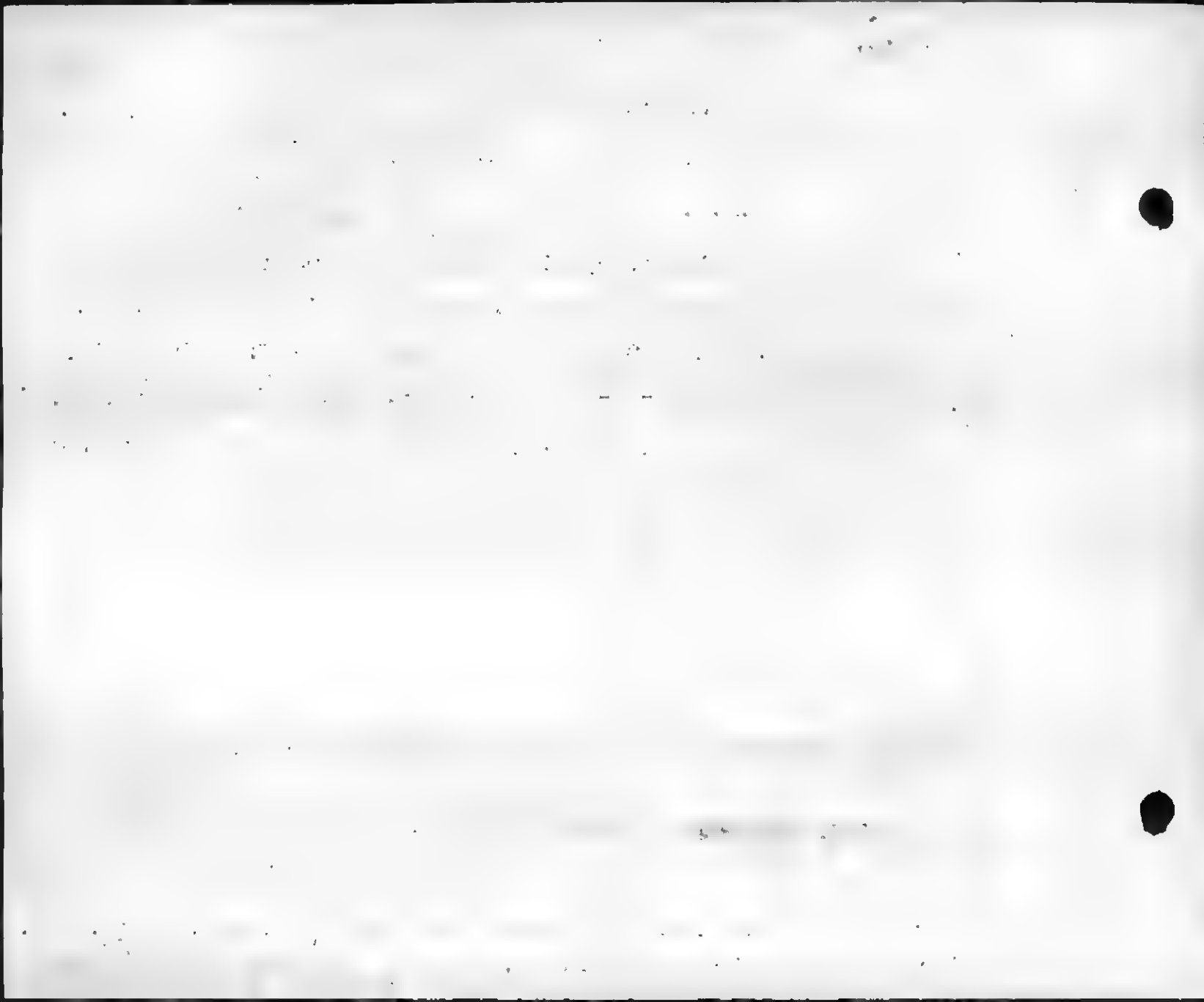


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-66

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Marab		Cecelia		Clark				Month Day Year April 13 1968			5:30 PM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR		IF UNDER 24 HRS	
Female		White		April 5, 1925		43 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore		Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Reisterstown		313 Cherry Hill Rd		Secretary		Railroad					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Baltimore		Reisterstown		X		313 Cherry Hill Rd.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Thomas Benjemin Small				Asenath Elizabeth Parker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		220-18-7217		Maynard E. Clark		313 Cherry Hill Rd. Reisterstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 114X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma rt. breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 mos. 4 yrs.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 110X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
8-18-64		Ca. rt. breast		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 12-16-63, 19, to 4-13-68, 19, that (I) (we) lost saw the deceased alive on 4-11-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D.D. Caples M.D.								22c. DATE SIGNED 4-15-68			
22d. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.								22e. ADDRESS 5 Hanover Rd., Reisterstown, Md. 21136			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) - (County) (State)					
Burial		April 16, 1968		Druid Ridge Cemetery		Pikesville, Balto., Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
H. J. Schardt		Owings Mills, Md.		DATE Apr 16 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

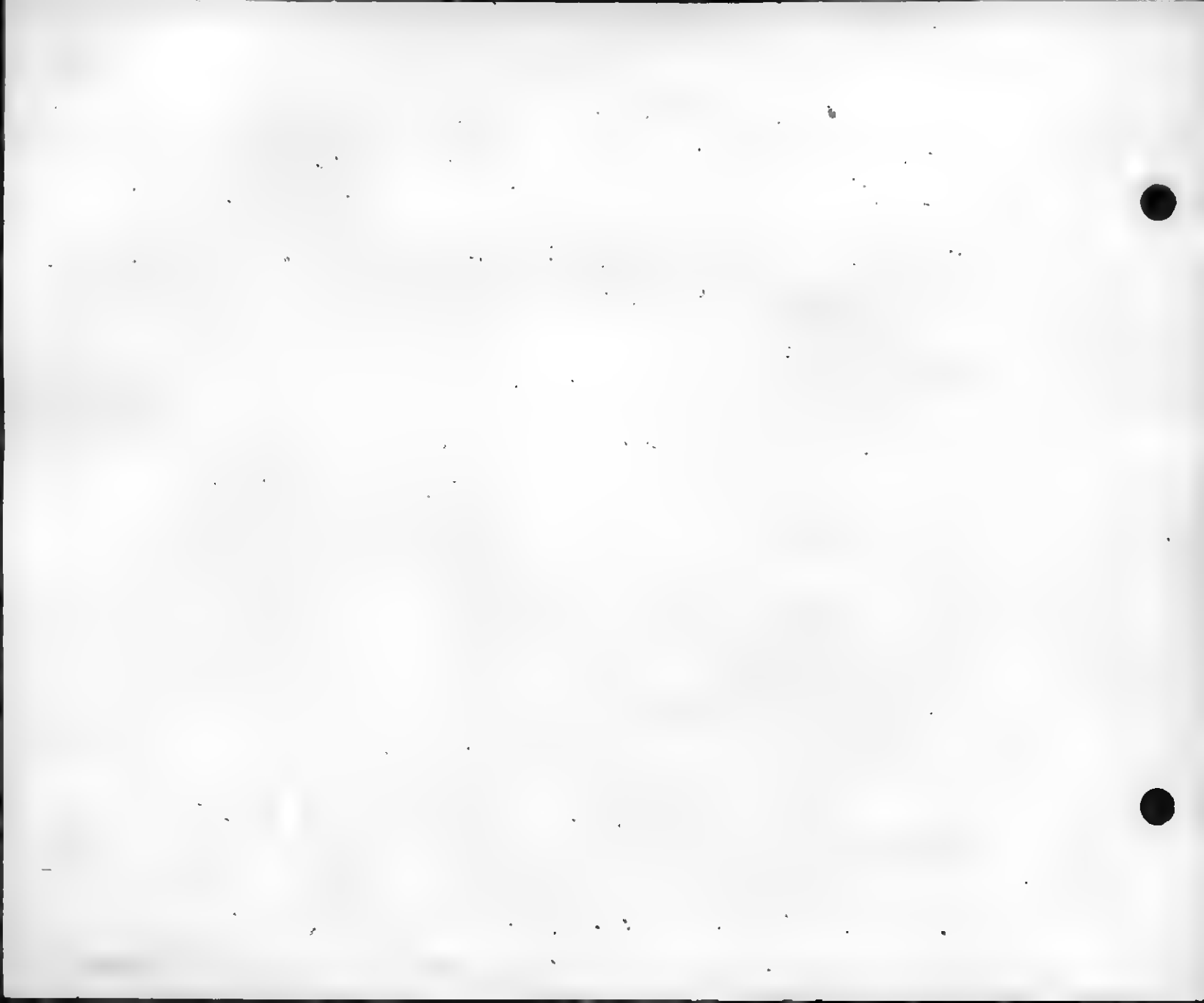
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

55205
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #5 & 6 Film 399 L/11/68 b1
CERTIFICATE OF DEATH

55205

1 DECEASED NAME (Type or print) Henry Clardy			2a. DATE OF DEATH Month 4 Day 6 Year 1968			2b. HOUR 2:25 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH July 10 - 1904		6 AGE (In years last birthday) 63 YRS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co. Md.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Molder		12b. KIND OF BUSINESS OR INDUSTRY Hopewell Co.	
13a. USUA. RES.DENCE (Where deceased lived if institution- Residence before admission) STATE Bere. Rd.		13b. COUNTY Balt. Co.		13c. CITY OR TOWN Baltimore		13e. STREET AND NUMBER 2934 Bere. Rd.	
14. FATHER'S NAME First John Middle Clardy Last Clardy				15. MOTHER'S MAIDEN NAME First Anna Middle Broger Last Broger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 220.05-9997		17 INFORMANT Mrs. Anna A. Clardy Address 2934 Bere. Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma 1514 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatous spread DUE TO, OR AS A CONSEQUENCE OF (c) stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1514							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-20 , 19 65 , to 4-6 , 19 68 , that (I) (we) last saw the deceased alive on 4-6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William H. K.				22c. DATE SIGNED 4-6-68		22d. PHYSICIAN'S NAME (Type) William H. K.	
22e. ADDRESS				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 10-68		23c. NAME OF CEMETERY OR CREMATORY London Mt.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24 FUNERAL DIRECTOR John J. Henry Inc.				25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	



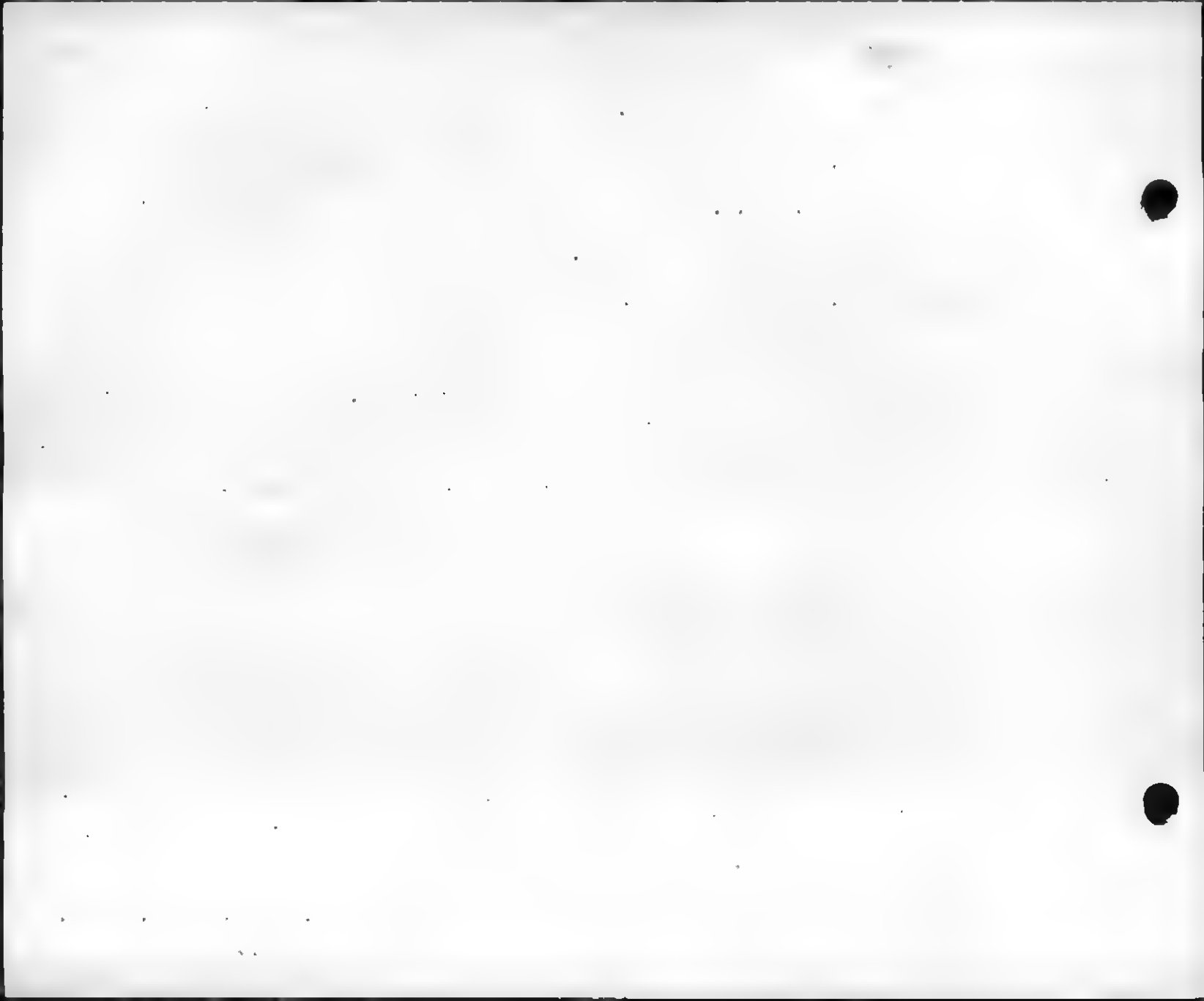
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) Carl		First Middle Last C. Class		2a DATE KNOWN OF DEATH MAY 28 1968		2b HOUR 3:30 PM	
3 SEX Male	4 RACE Cau.	5 DATE OF BIRTH 6-30-1913	6 AGE (in years last birthday) 51 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7c DATE PRONOUNCED DEAD MAY 28 1968	
7a BIRTHPLACE (State or foreign country) Baltimore Co.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager		12b KIND OF BUSINESS OR INDUSTRY Essex Lumber	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Parkville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Charles Frederick Class		15 MOTHER'S MAIDEN NAME Goldie Deise		13e STREET AND NUMBER 21234		13f ADDRESS 3020 Woodside Avenue	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 217-15-1772		17 INFORMANT Mrs Jerryleen A. Class		17b ADDRESS 21234	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Secondary Occlusion Sudden DUE TO, OR AS A CONSEQUENCE OF (b) Secondary Insufficiency 2+ yrs DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4109							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles F. O'Donnell, M.D. EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) 22b DATE SIGNED 4/28/68							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5-1-1968		23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24 FUNERAL DIRECTOR Lorraine Funeral Home		25a REC'D BY REGISTRAR DATE MAY 2 1968		25b REGISTRAR'S SIGNATURE Charles Judge			

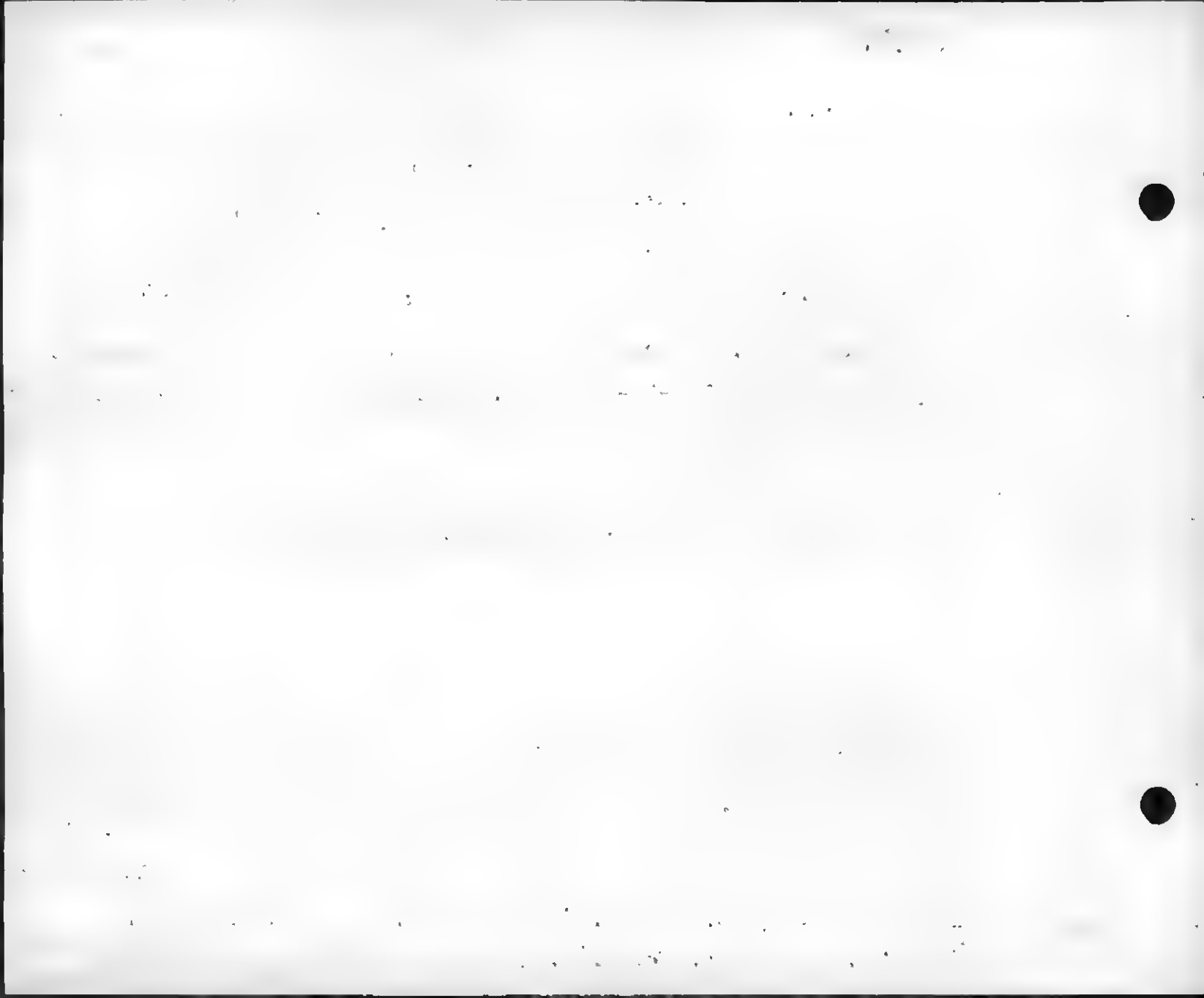


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 18

MIDDLE										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b. HOUR		
EARL JOSEPH COCHRAN						APRIL 10, 1968		2:10 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		JUNE 29, 1929		38 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
PENNSYLVANIA		U.S.A.				BALTIMORE, Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL			SOCIAL SECURITY				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND					BALTIMORE				5513 SEWARD AVE. #21206	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Earl L. Cochran			Rose Schlewinski							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes			215-24-1240		Mrs. Marlene Cochran		(Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cardiac arrest										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Uremia										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Chronic renal insufficiency										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (X) (this hospital) attended the deceased from APRIL 9, 1968, to APRIL 10, 1968, that (X) (we) last saw the deceased alive on APRIL 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		22c. DATE SIGNED		
Ines Cilliani, M.D.						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		April 10, 1968		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
						7620 York Rd., Towson, Md. 21204				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		4/15/68.		Balto. National Cem.		Baltimore, Md.				
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Ints. Balto. Md. 21214						DATE 11 1968		Charles Judge		



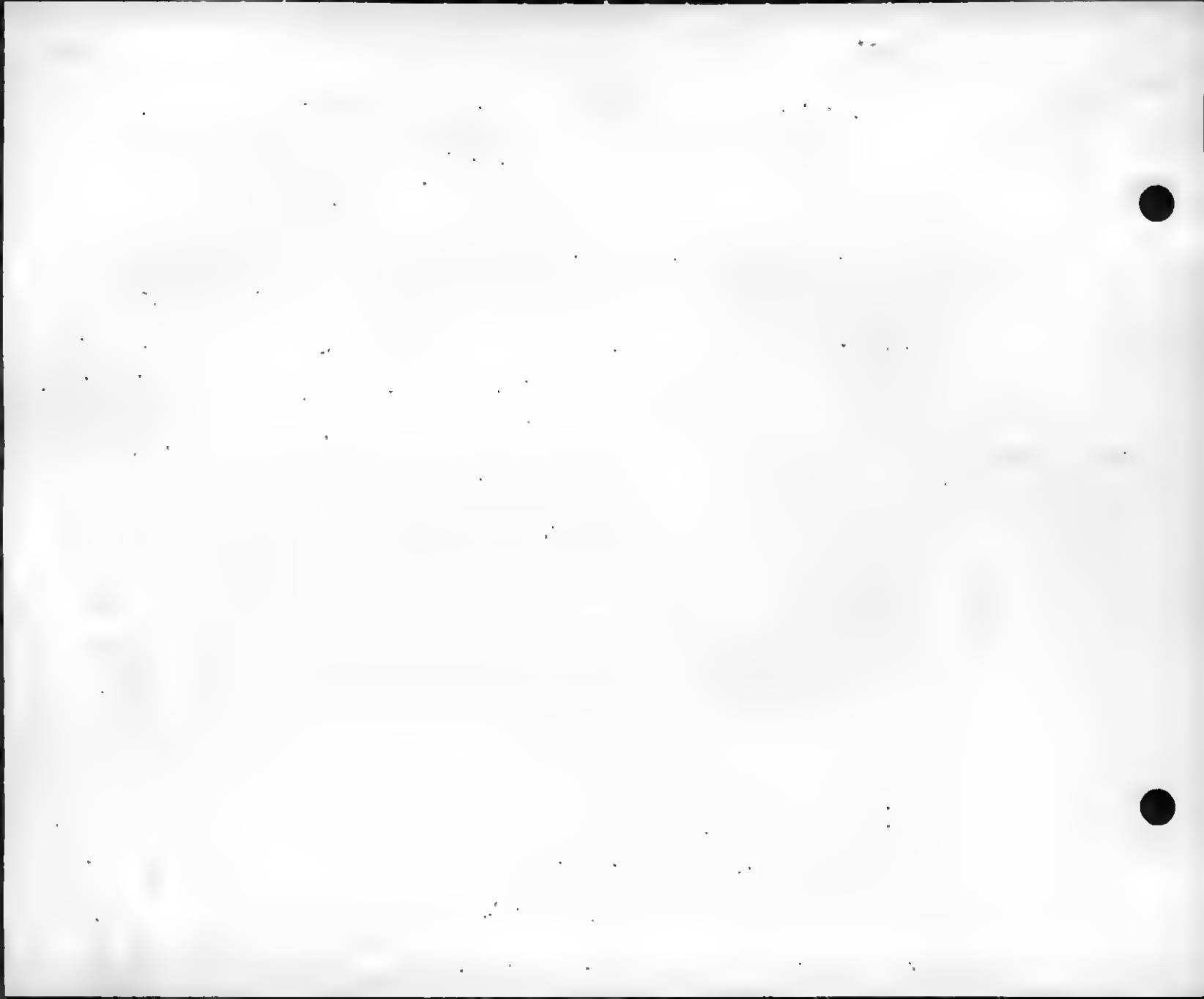
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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30M REV. 1/68

1
20204
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SYDNE V. COCHRANE		2a. DATE OF DEATH APRIL Month 13 Day 1968 Year		2b. HOUR M
3 SEX F	4 RACE W	5 DATE OF BIRTH AUG. 29, 1888		6 AGE (In years last birthday) 79 YRS.
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md.
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 406 OAK FOREST AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEKEEPER
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY BALTO	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last CHARLES E. COCHRANE		15. MOTHER'S MAIDEN NAME First Middle Last ANNABELLE HALL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. —	17. INFORMANT Address William H. Thompson - 406 Oak Forest Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage 2 weeks DUE TO, OR AS A CONSEQUENCE OF (b) Fractured Hip - 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) Cancer - expanding - metastatic 6 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1948 to April 2, 1968 , that (I) (we) last saw the deceased alive on April 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Frederic V. Beitler		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-24-68
22d. PHYSICIAN'S NAME (Type) FREDERIC V. BEITLER		22e. ADDRESS 1014 Downers Ave - (Jesse M) W		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-25-1968	23c. NAME OF CEMETERY OR CREMATORY Grand Ridge Cem.	23d. LOCATION (City or Town) (County) (State) Catonsville Ind.	
24. FUNERAL DIRECTOR Forley C. Cunningham 27 N. Catonsville Ind.		25a. BY REGISTRAR APR 26 1968		25b. REGISTRAR'S SIGNATURE William H. Thompson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD205
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last SHIRLEY MAE COCKERHAM			2a. DATE OF DEATH Month Day Year 4 25 68			2b. HOUR 4 45 P M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 2-10-66		6. AGE (In years last birthday) 2 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY U. S. A.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 1245 Willow Road.		14. FATHER'S NAME First Middle Last ARLEN B COCKERHAM		15. MOTHER'S MAIDEN NAME First Middle Last SHIRLEY JEFFERIES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Mr. Arlen B. Cockerham, 1245 Willow Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Splenic abdominal hemorrhage from the liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive hepatomegaly secondary to tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension + cardiac arrest</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from 4/23, 1968, to 4/25, 1968, that (I) (we) last saw the deceased alive on 4/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jeffrey F. Mitchell</i>				22c. DATE SIGNED 4/25/68		22d. PHYSICIAN'S NAME (Type) Mitchell	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

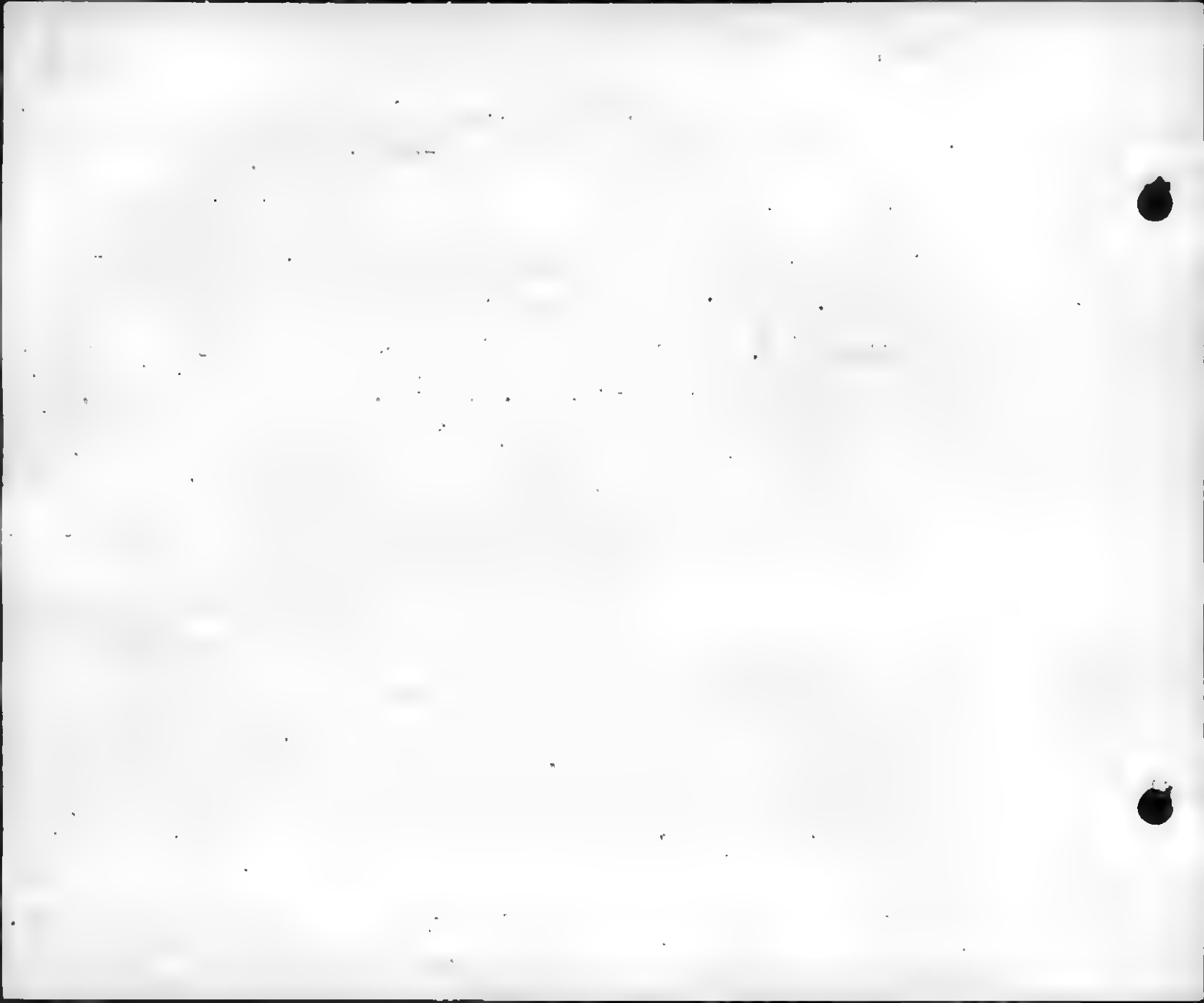
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VR A15 (4)
30M REV. 1/68

05206

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR PM	
Ethel		Bertrand	Cogswell		4 28 68			12:10	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS M.N.
Female	White		12-24-30 1880		37 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		United States				Baltimore County Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Lutherville		College Manor Nursing Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Pikesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Old Court Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William T. Cox			Francis Rebecca Benson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT					
No		220-44-3983		Mr. William K. Cogswell, 1015 Converse Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									10 days
432.9 DUE TO, OR AS A CONSEQUENCE OF									6 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									5 years
(c) arteriosclerosis (cardiac)									
(b) arteriosclerosis									
(c) arteriosclerosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1968, to April 28, 1968, that (I) (we) last saw the deceased alive on April 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Palmer F.C. Williams M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED May 1, 68	
22d. PHYSICIAN'S NAME (Type) PALMER F.C. Williams								22e. ADDRESS Linson Rd. Owings Mills Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 1, 1968		Druid Ridge Cemetery		Pikesville Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Frank H. Newell				Pikesville, Md.		MAY 7 1968		John J. Judge	



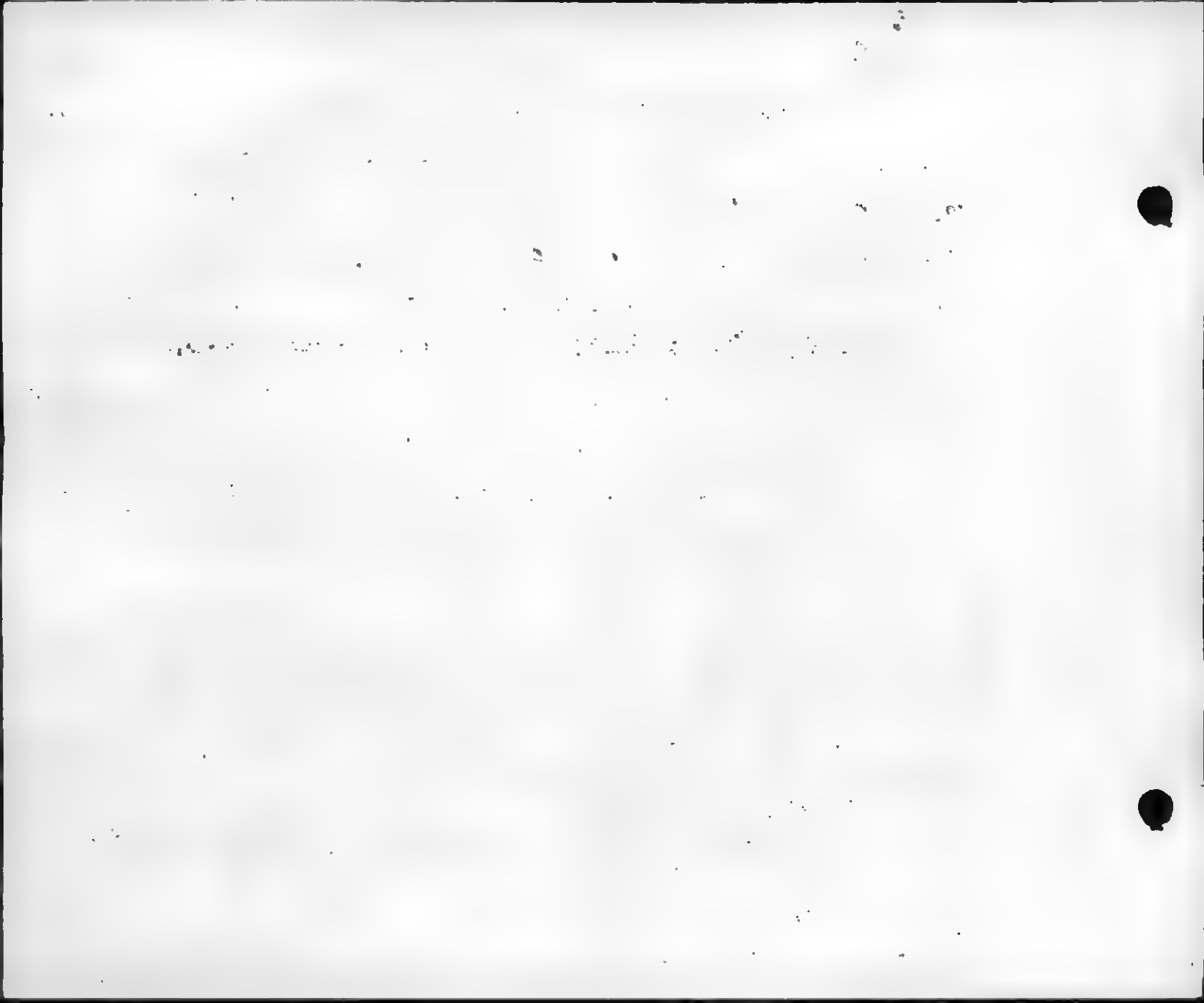
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VR A15 (4)
30M REV 1/68

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) THOMAS MARTIN CONNELLY			2a. DATE OF DEATH Month APRIL Day 3 Year 1968		2b. HOW LONG 2:20 HOURS 0 MIN
3 SEX MALE	4. RACE CAUC	5. DATE OF BIRTH 10-4-85		6. AGE (In years lost birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) PITTSBURG	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCKING BUSINESS	12b. KIND OF BUSINESS OR INDUSTRY SAME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3208 TOLEDO PLACE	
14. FATHER'S NAME First MARTIN Middle GEORGE Last CONNELLY	15. MOTHER'S MAIDEN NAME First MARY Middle UNKNOWN Last DANIELS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 028-20-7531		17. INFORMANT JOSEPH SPISICK Address 3208 TOLEDO PLACE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) SENILITY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) U.S.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July 13, 1967 , to April 3, 1968 , that (I) (we) last saw the deceased alive on April 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Narciso Aristigueta M.D. DEGREE		22c. DATE SIGNED 4-3-68		22d. PHYSICIAN'S NAME (Type) NARCISO ARISTIGUETA	
22e. ADDRESS Baltimore, Maryland 21228		22f. ADDRESS SPRING GROVE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE April 6, 1968	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) Washington	(County) (State) D.C.	
24. FUNERAL DIRECTOR Thomas Funeral Home, J. Arthur Waller, 274 Carroll (N.W.)		25a. REC'D BY REGISTRAR APR 5 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

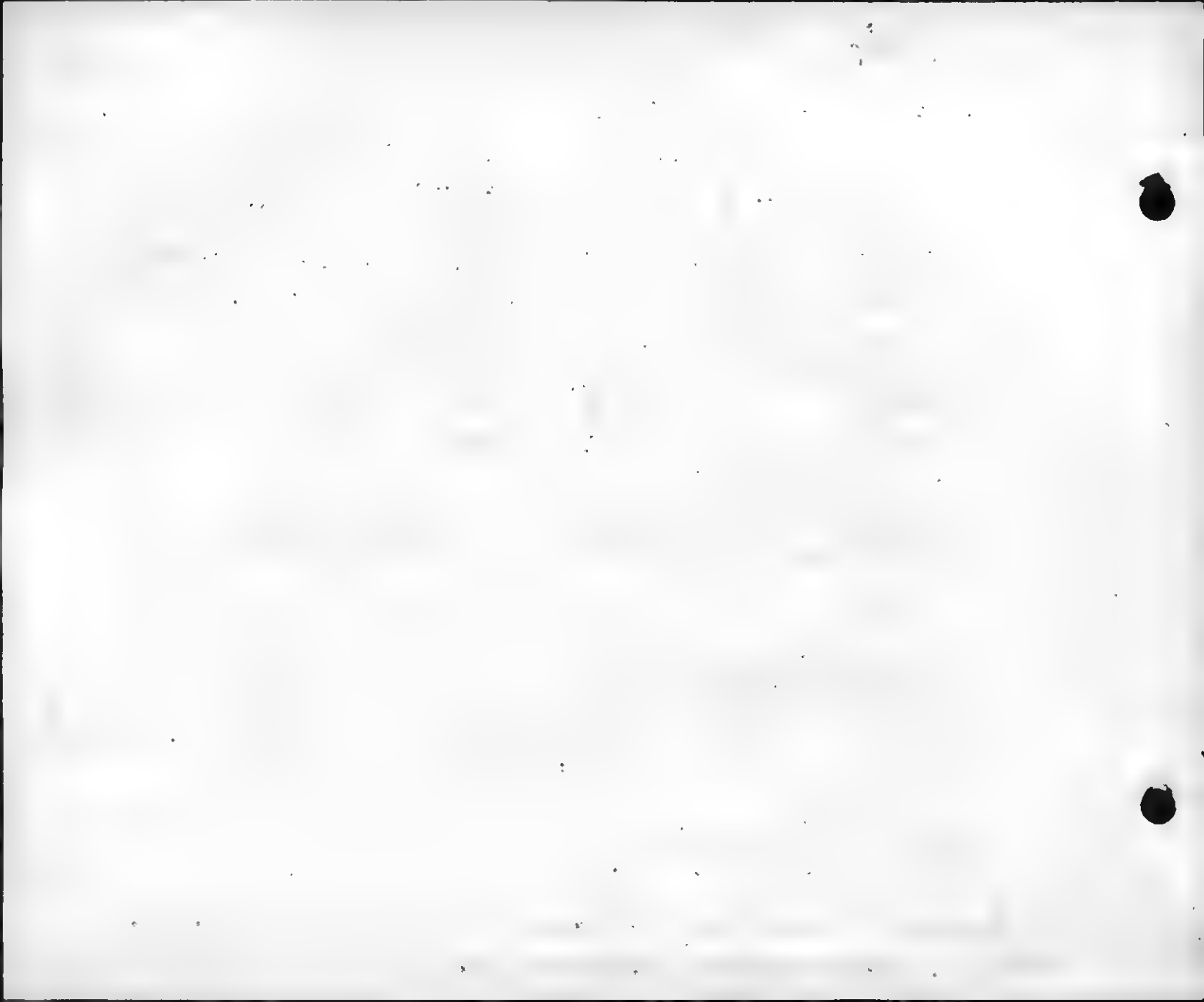


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MEDICAL CERTIFICATION

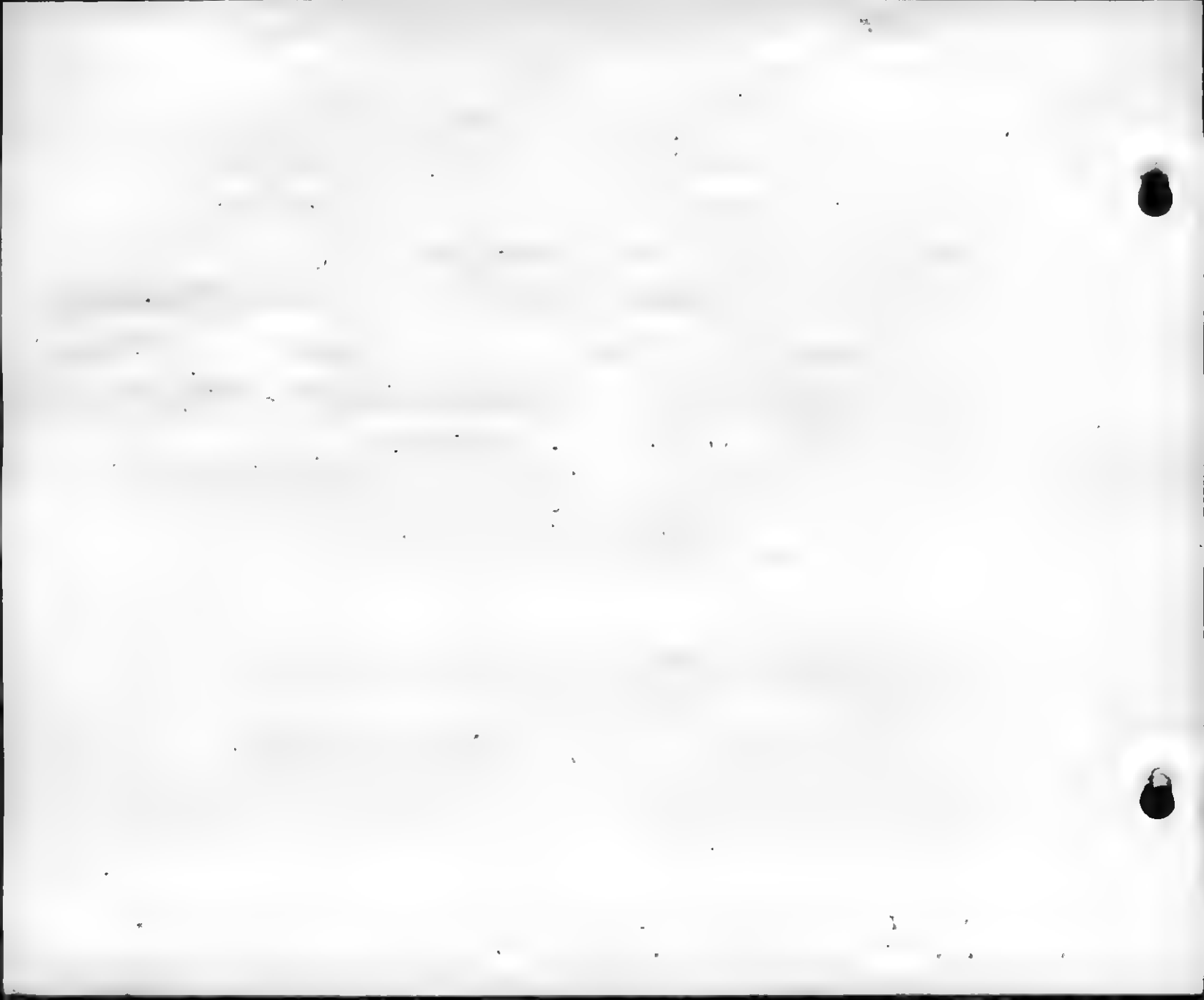
1. DECEASED NAME (Type or print) MARY ANNE COUGHLIN			2a. DATE OF DEATH Month APRIL Day 7 Year 1968			2b. HOUR 9 55PM	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH 1-15-87		6 AGE (in years last birthday) 81 YRS.	
7a BIRTHPLACE (State or foreign country) IRELAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md	
10 CITY OR TOWN OF DEATH Mount Wilson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TEACHER VISITATION SISTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY - HTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 5712 ROLAND AVE		14 FATHER'S NAME First Middle Last JOHN CROTTY		15 MOTHER'S MA DEN NAME First Middle Last MARGARET DAVINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 220-541-2916		17 INFORMANT Address Records, Mt. Wilson State Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) FAR ADVANCED PULM T.B ACTIVE DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-25 , 1968, to 4-7 , 1968, that (I) (we) last saw the deceased alive on 4-7 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William Newcomer DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 9/68		23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.				25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MAYLAND 21201											
Item 13 Film G400 5/2/68											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Miss Mary A		A				Creaghan		4 Month 13 Day 68 ^{or}		1:45 P M	
3 SEX		A. RACE		5 DATE OF BIRTH		6 AGE (n years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Sept 14 1892		75 76 YRS.		MONTHS DAYS HOURS MIN		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md	
Unknown		America				Baltimore					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Baltimore		Summit Nursing Home		AT HOME							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		331 W. Lombard St	
Md		Baltimore		Baltimore				918 North Ave			
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Ostrich		J.				Creaghan		Margaret		O'Brien	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
						(Spouse for record) Catherine J. Stump, R.D.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) PULMONARY EMBOLUS											
DUE TO, OR AS A CONSEQUENCE OF FRACTURED HIP, left femur at BOW SECOURS											
(b) AORTIC STENOSIS											
DUE TO, OR AS A CONSEQUENCE OF A SCVD											
(c) Multiple decubital ulcers											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION											
19b CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)											
21f. LOCATION Street or R.F.D. No City or Town County State											
22a I certify that (I) (this hospital) attended the deceased from March 7 1968, to April 13, 1968, that (I) (we) last saw the deceased alive on 4/12 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death Natural causes											
22b SIGNATURE E. KASATI'S, M.D.											
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c DATE SIGNED 4/13/68											
22d. PHYSICIAN'S NAME (Type) E. KASATI'S, M.D.											
22e. ADDRESS 1801 FREDERICK RD; BALTIMORE MD 21228											
23a BURIAL, CREMATION, REMOVAL (Specify)											
23b DATE 4/16/68											
23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL											
23d LOCATION (City or Town) (County) (State) BALTIMORE MD.											
24 FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST											
25a REC'D BY REGISTRAR DATE APR 17 1968											
25b. REGISTRAR'S SIGNATURE J. Charles Judge											

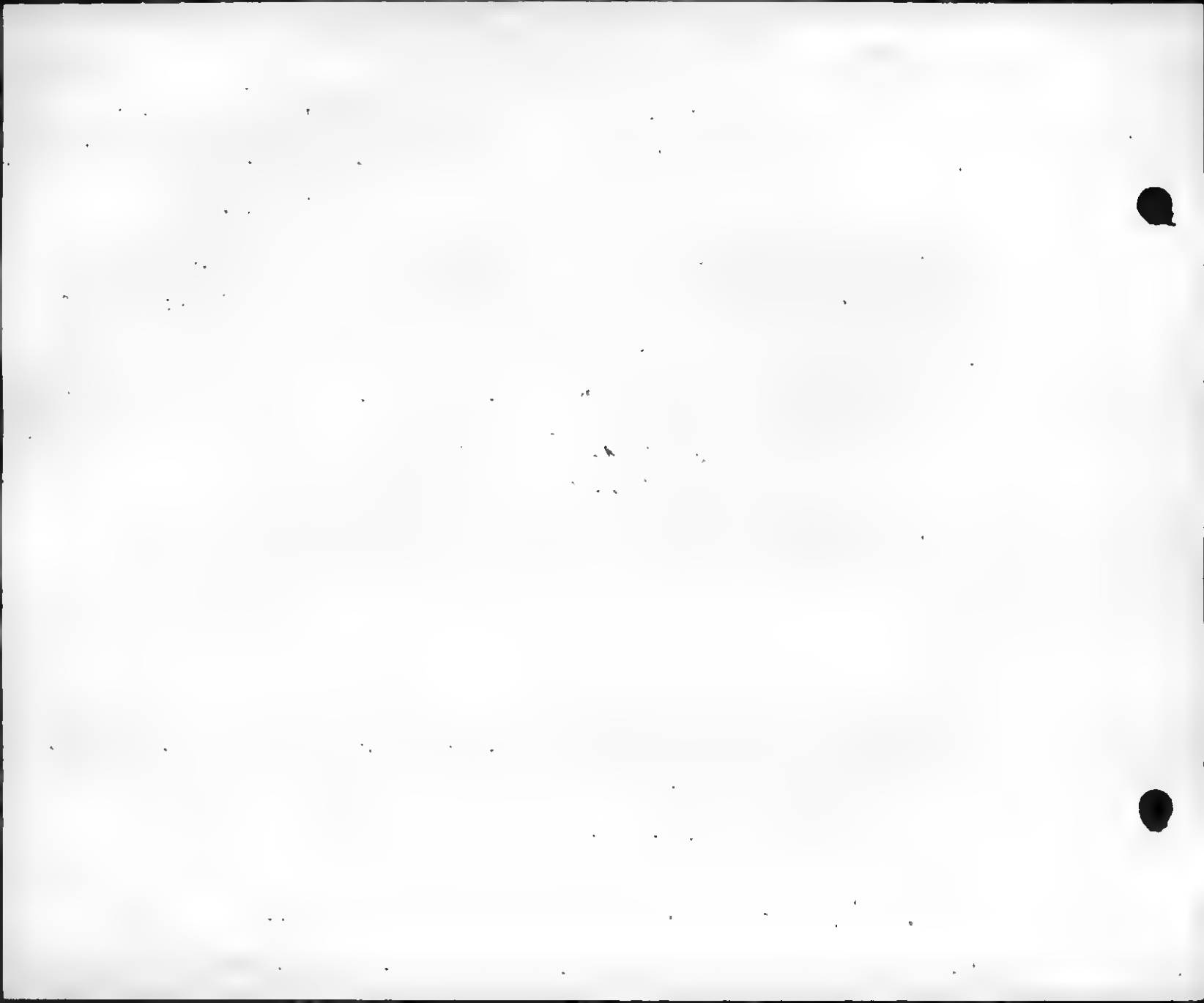


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

35210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) William Stewart		First William Middle Stewart Last Crichton		2a. DATE OF DEATH Month April Day 28 Year 1968		2b. HOUR 11:00 PM	
3 SEX male		4 RACE white		5. DATE OF BIRTH MAY 17 1892		6. AGE (In years last birthday) 76 YRS	
7a. BIRTHPLACE (State or foreign country) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Duanny Tewson Nush Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LANDSCAPING		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1007 KATY LANE		14. FATHER'S NAME First Crichton Middle JoAnn Last Crichton		15. MOTHER'S MAIDEN NAME First JoAnn Middle Crichton Last Crichton		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name () (If yes give war or dates of service) NO	
16b. SOCIAL SECURITY NO 371-05-3485		17. INFORMANT Mrs. Richard F. Meehan		Address 1007 Katy Lane 21204		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease DUE TO, OR AS A CONSEQUENCE OF (c) last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from January, 1966 to April, 1968 , that (I) (we) last saw the deceased alive on April 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE A. Allan Lier, MD		22c. PHYSICIAN'S NAME (Type) A. Allan Lier, MD		22d. ADDRESS DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED 4/28/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 5/1/68		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR MAY 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

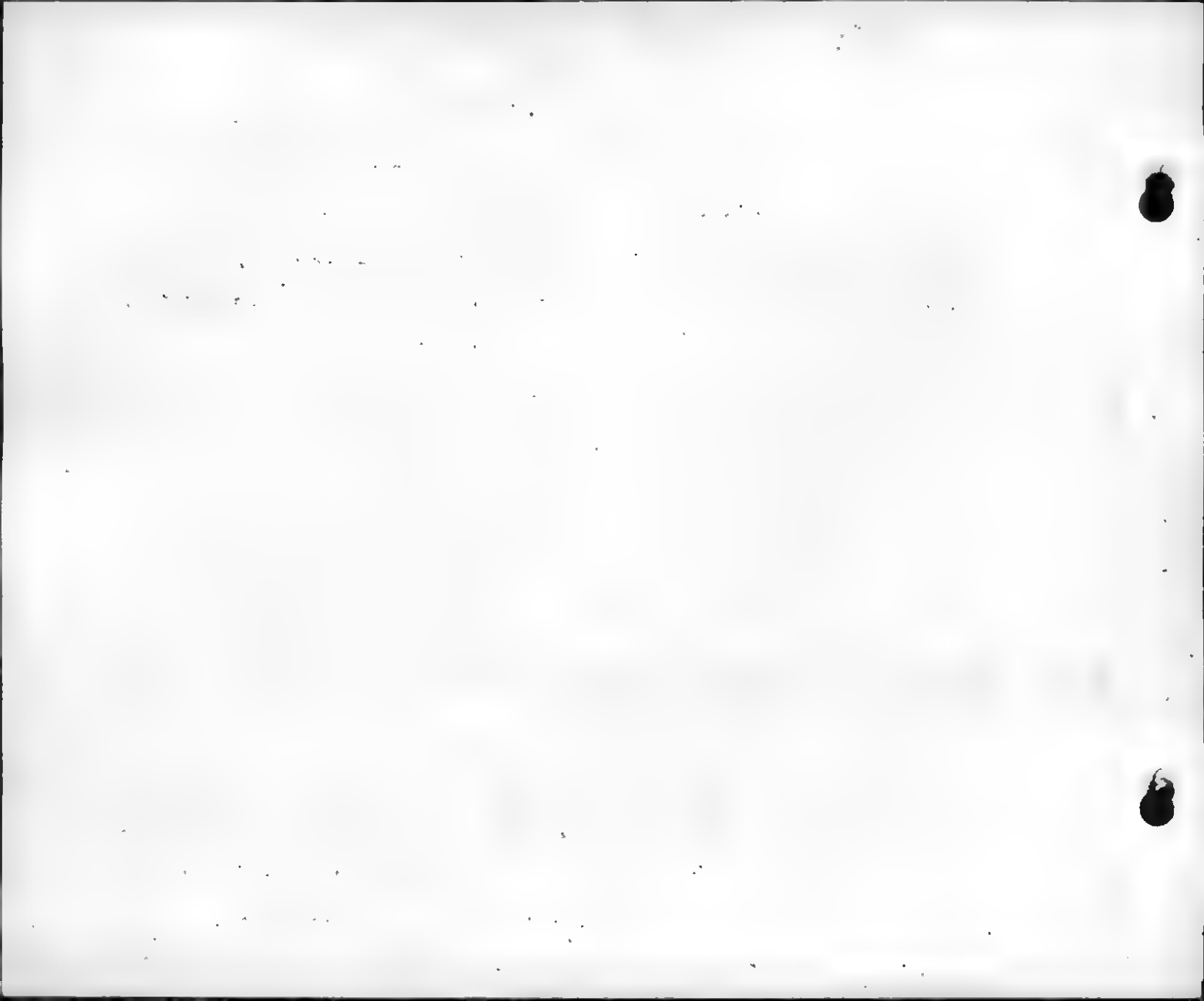


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M											
05211											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
05215											
1. DECEASED NAME (Type or print)			First Sadie			Middle U.			Last CROISSETTE		
3. SEX Female			4. RACE White			5. DATE OF BIRTH June 11, 1892			2a. DATE OF DEATH Month April Day 4 Year 1968 2b. HOUR 7:45 AM		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY CANDY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 3009 Linwood Ave.			14. FATHER'S NAME First ISSAC Middle CUDDY Last MATILDA BISCOE			15. MOTHER'S MAIDEN NAME First MATILDA Middle BISCOE Last BISCOE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No. (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 203X			17. INFORMANT Mr. Stanley Griffiths - 309 Linwood Ave.			Address		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple myeloma 203X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 203X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month 19 Day 19 Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that (X) (this hospital) attended the deceased from 3/30/1968 to 4/4/1968 , that (X) (we) last saw the deceased alive on 4/4/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Vichian Phupakdi			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED April 4, 1968		
22d. PHYSICIAN'S NAME (Type) Vichian Phupakdi, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-6-68			23c. NAME OF CEMETERY OR CREMATORY WOODLAWN Cem.			23d. LOCATION (City or Town) (County) (State) BALTO., MD.		
24. FUNERAL DIRECTOR Stanley Miller			ADDRESS 2334 JEFFERSON ST.			25a. REC'D BY REGISTRAR APR 8 - 1968			25b. REGISTRAR'S SIGNATURE Stanley Miller		

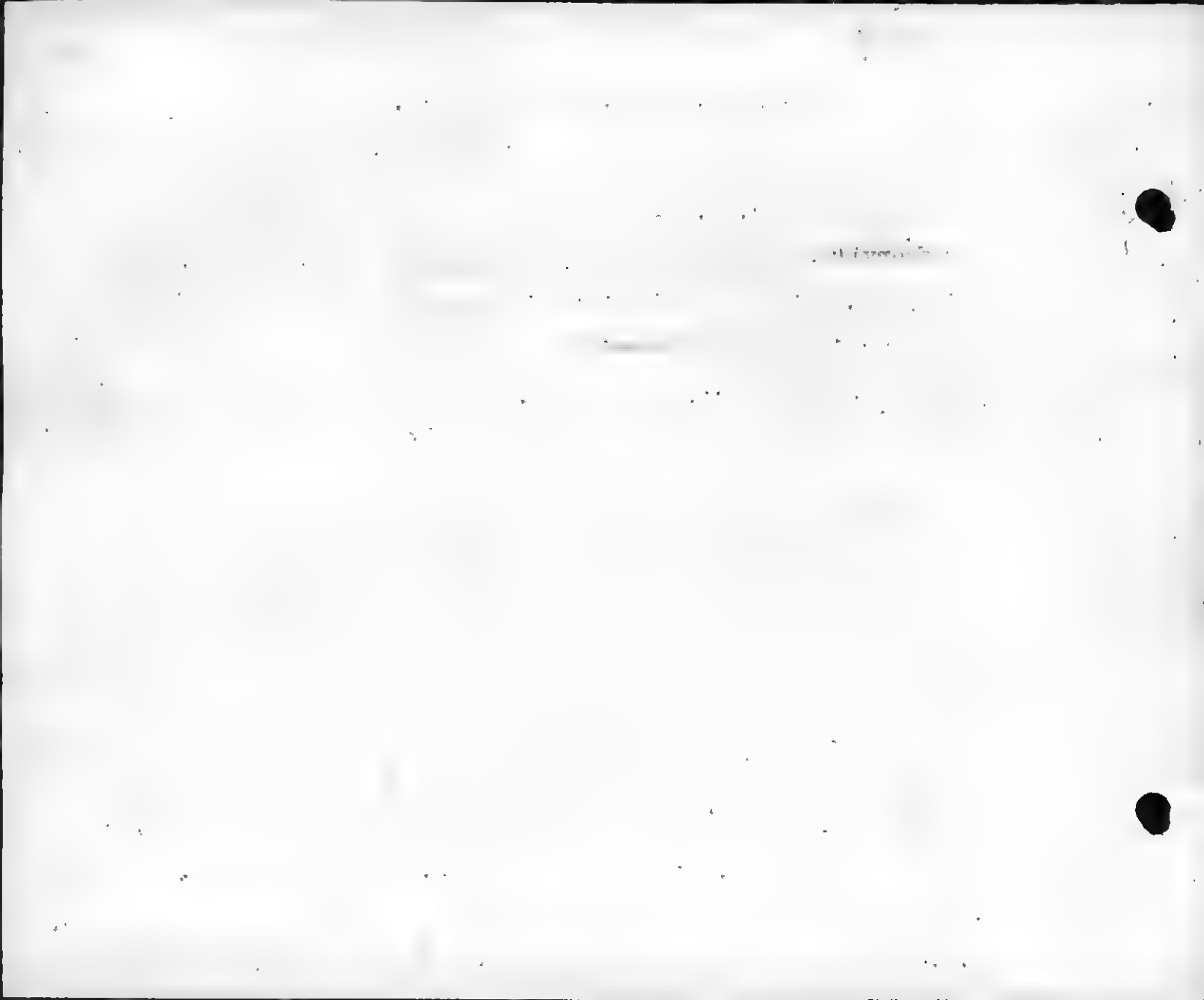
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print) Michael Jenkins Cromwell, Sr.						2a. DATE OF DEATH Month April Day 30 , Year 1968			2b. HOUR 8:00 A M				
3. SEX M		4. RACE W		5. DATE OF BIRTH 10/25/1901			6. AGE (In years last birthday) 66 YRS		7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Lutherville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 504 RD#1, Lutherville			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) President P.J. McEvoy & Sons			12b. KIND OF BUSINESS OR INDUSTRY Importers				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Riderwood			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Box 504- RD #1	
14. FATHER'S NAME First William Middle Kennedy Last Cromwell						15. MOTHER'S MAIDEN NAME First Sally Middle Franklin Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WWII						16b. SOCIAL SECURITY NO. 212-09-5663		17. INFORMANT Address Mrs. Maria McEvoy Cromwell (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 185 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177 X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State 							
22a. I certify that (I) (this hospital) attended the deceased from June 1962 , to April 30, 1968 , that (I) (was) last saw the deceased alive on April 30, 1968 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.													
22b. SIGNATURE William F. Fritz MD						DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4/30/68				
22d. PHYSICIAN'S NAME (Type) William F. Fritz M.D.						22e. ADDRESS 2 W. University Plwy.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/2/68			23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						ADDRESS 1905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR MAY 3 1968		25b. REGISTRAR'S SIGNATURE [Signature]		

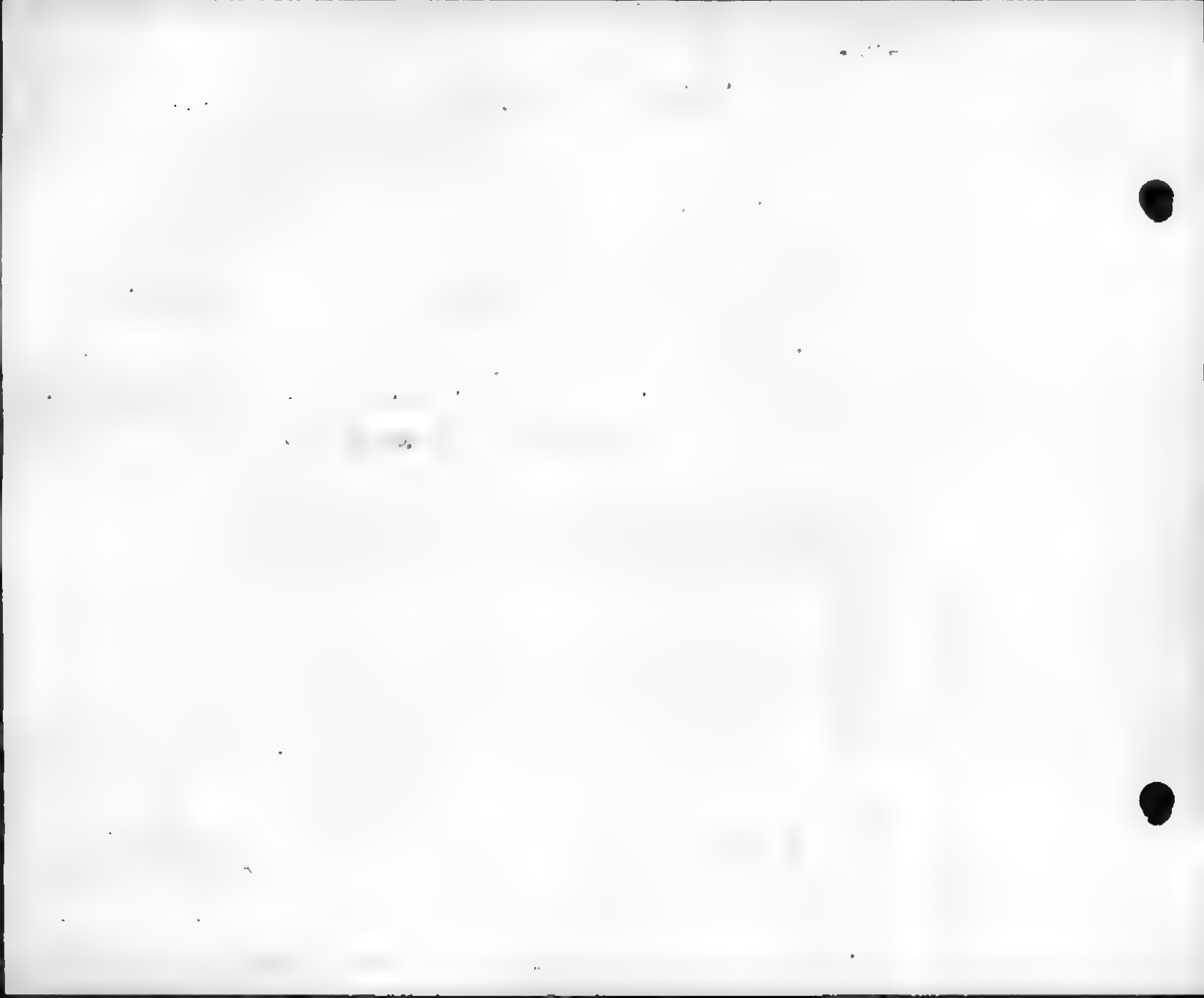


FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHE-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) James Francis Middle Dalton JAMES FRANCIS DALTON					2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year APR 29 1968			2b HOUR 6:30 P M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 3/5/1901		6 AGE (In years last birthday) 67 YRS		7c DATE PRONOUNCED DEAD Month 4 Day 29 Year 1968	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH White Hall			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) West Liberty Road			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b KIND OF BUSINESS OR INDUSTRY Farming	
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b CITY OR TOWN Baltimore			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER RD # 2, Box 104	
14 FATHER'S NAME First Middle Last John T. Dalton				15. MOTHER'S MAIDEN NAME First Middle Last Viola Shawn					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO 219-36-0763		17 INFORMANT Mrs. Margaret L. Dalton		ADDRESS RD #2 Box 104 White Hall, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 410.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								21161 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) T2101									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR AM P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE A.M. France				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) A.M. FRANCE				ADDRESS (Street, city, town or county) PARKTON, Md.		22b DATE SIGNED 4/29/68			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 5/2/1968		23c NAME OF CEMETERY OR CREMATORY St. Johns		23d LOCATION (City or Town) (County) (State) Hyde, Baltimore, Maryland			
24 FUNERAL DIRECTOR Charles E. Kurtz Jarrettville, Md.				25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 01 1968	

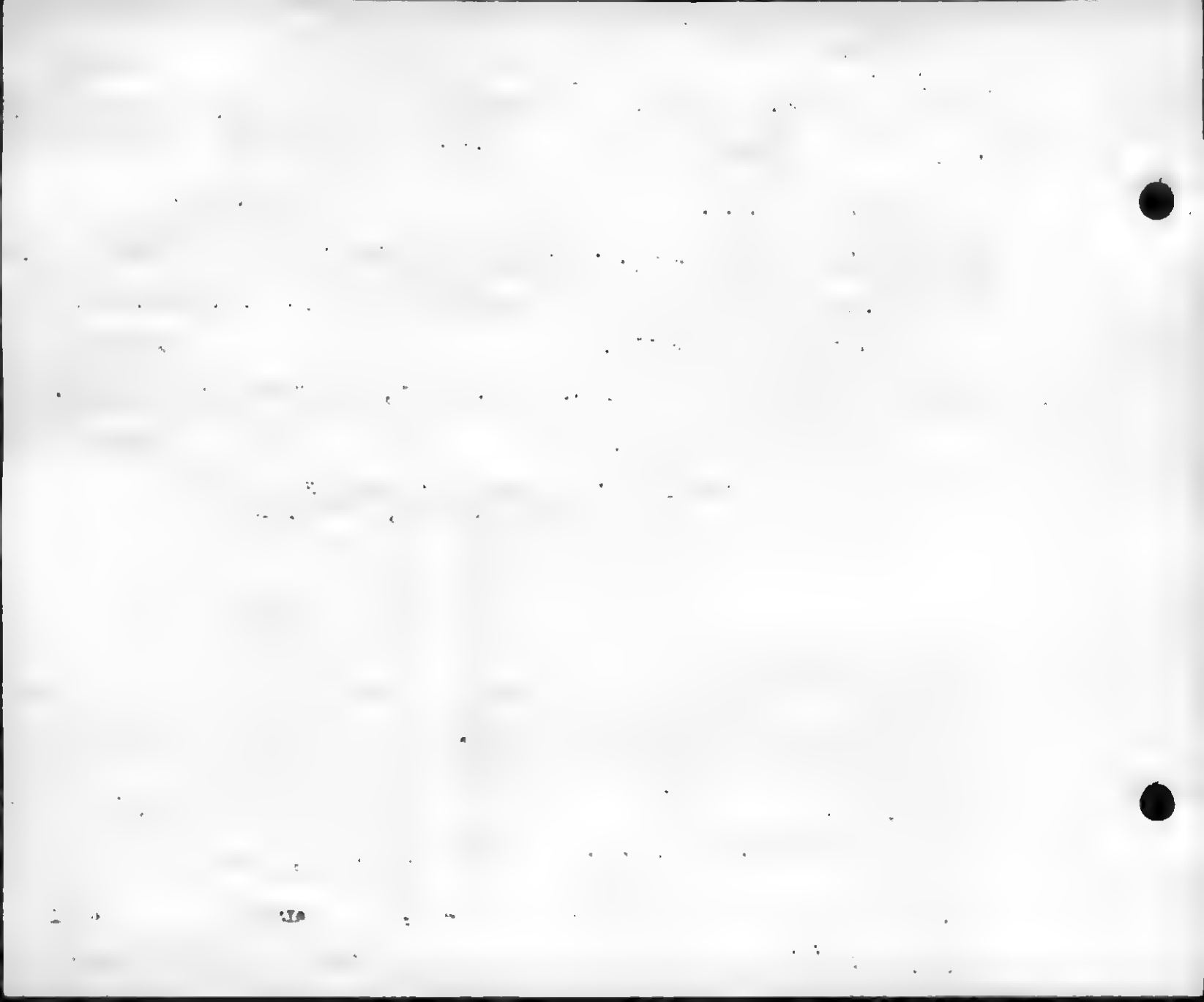


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
30M REV 1-66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																
1. DECEASED NAME (Type or print)			First RALPH			Middle EARL			Last DAWSON			2a. DATE OF DEATH Month APRIL Day 1 Year 1968			2b. HOUR 2:30 PM	
3. SEX MALE			4. RACE NEGRO			5. DATE OF BIRTH 2/3/32			6. AGE (In years last birthday) 36 YRS			IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 		
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY,			Md.				
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR IND. STRY SHIP BUILDING							
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIM TSY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER 1103 N. Fulton Avenue				
14. FATHER'S NAME First FRED Middle CRAWFORD Last ADA			15. MOTHER'S MAIDEN NAME First ADA Middle DAWSON Last DAWSON													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) PL 28			16b. SOCIAL SECURITY NO 239 42 02 72			17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 1621 DUE TO, OR AS A CONSEQUENCE OF BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASIS TO LYMPH NODES, LUNG, KIDNEY AND BRAIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) /																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal. examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (a) (this hospital) attended the deceased from 2/24/68 , 19 68 , to 4/1/68 , 19 68 , that (b) (we) last saw the deceased alive on 4/1/68 , 19 68 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Peter J. Juvan</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 4/2/68						
22d. PHYSICIAN'S NAME (Type) PETER J. JUVAN, M. D.										22e. ADDRESS VAH FORT HOWARD, MARYLAND						
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-5-68			23c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND							
24. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME 1701 LAURENS, BALTIMORE, MARYLAND						25a. REC'D BY REGISTRAR DATE APR 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



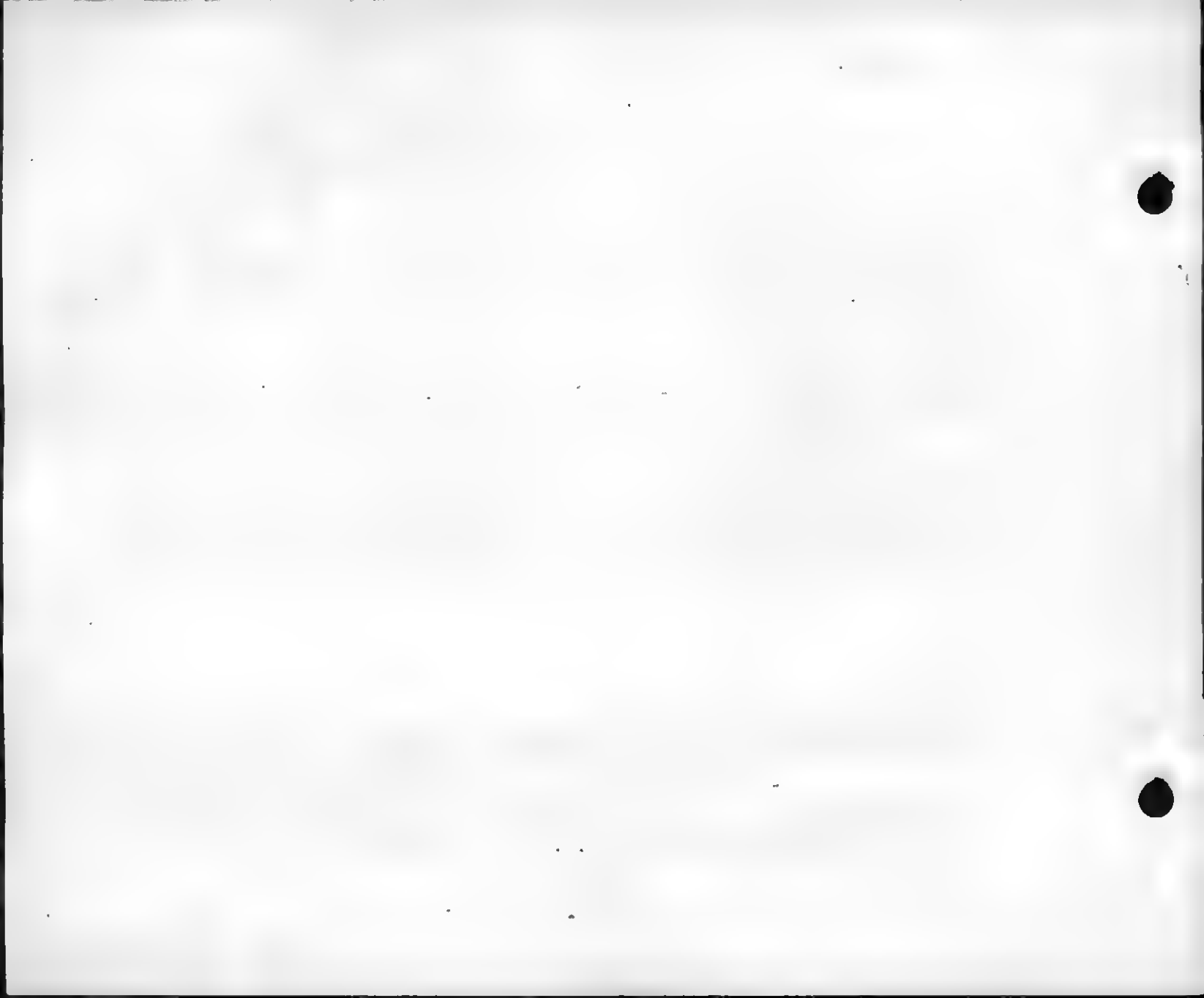
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13c File # 3399 1-1-388 1-1-388
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First CALVIN	Middle Martin	Last DEAN	2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 4 Year 1968		2b HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH 8-14-95	6 AGE (in years last birthday) 72 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0	2c DATE PRONOUNCED DEAD Month April Day 4 , Year 1968	2d HOUR 1:20 AM
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Martin Middle Dean Last Dean		15. MOTHER'S MAIDEN NAME First Rebecca Middle Dean Last Dean		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 212-10-1161	
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		17 INFORMANT Mrs. Gladys A. Dean		ADDRESS 1031 Maiden Choice Lane		21229	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 5/11/1 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 581							
19a DATE OF OPERATION 5/11/1		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town County State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED April 4, 1968	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 4/8/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Md.	
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229		25a REC'D BY REGISTRAR APR 8 - 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

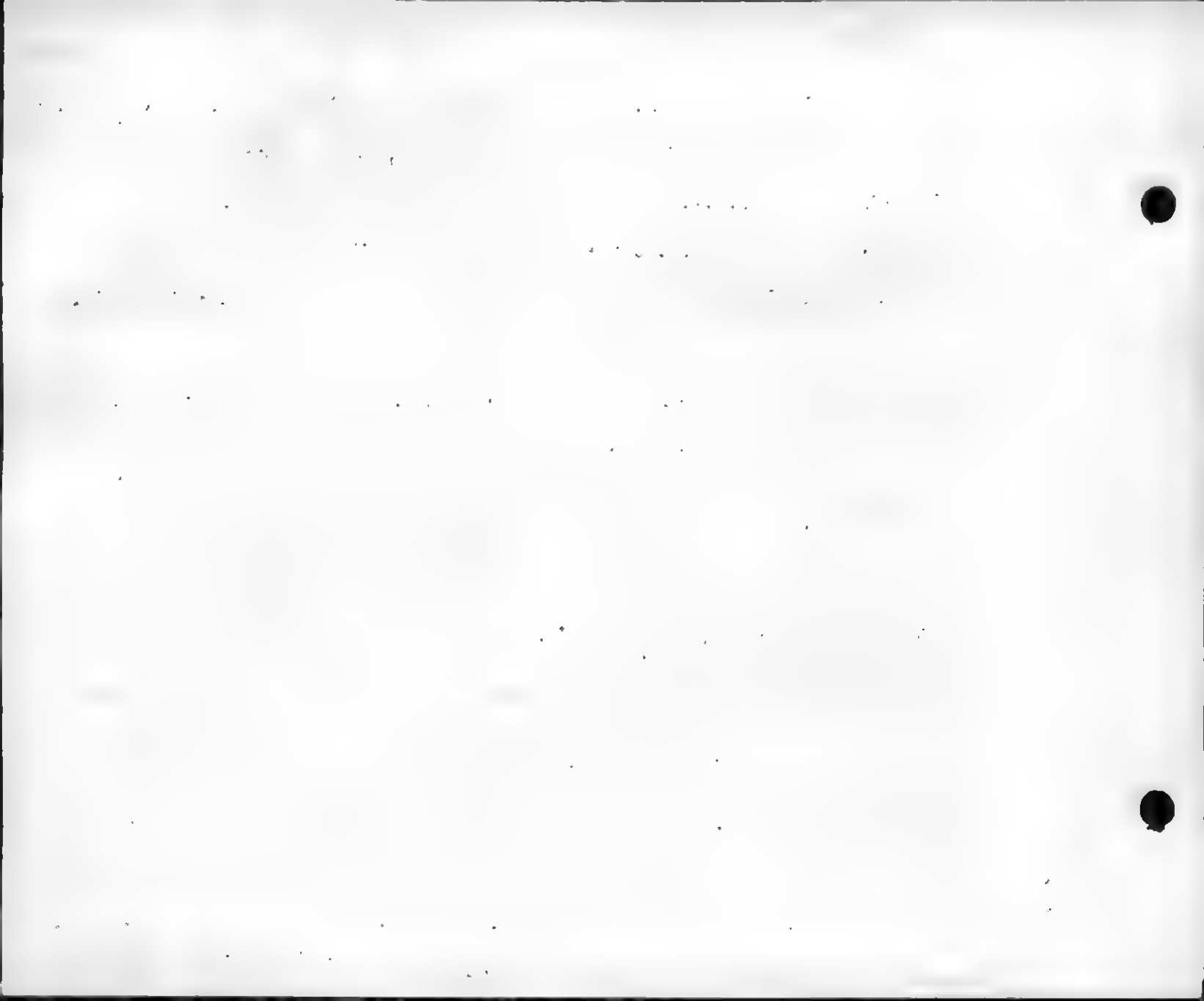
VR A15 (4)
30th REV 1/68

05216

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05220

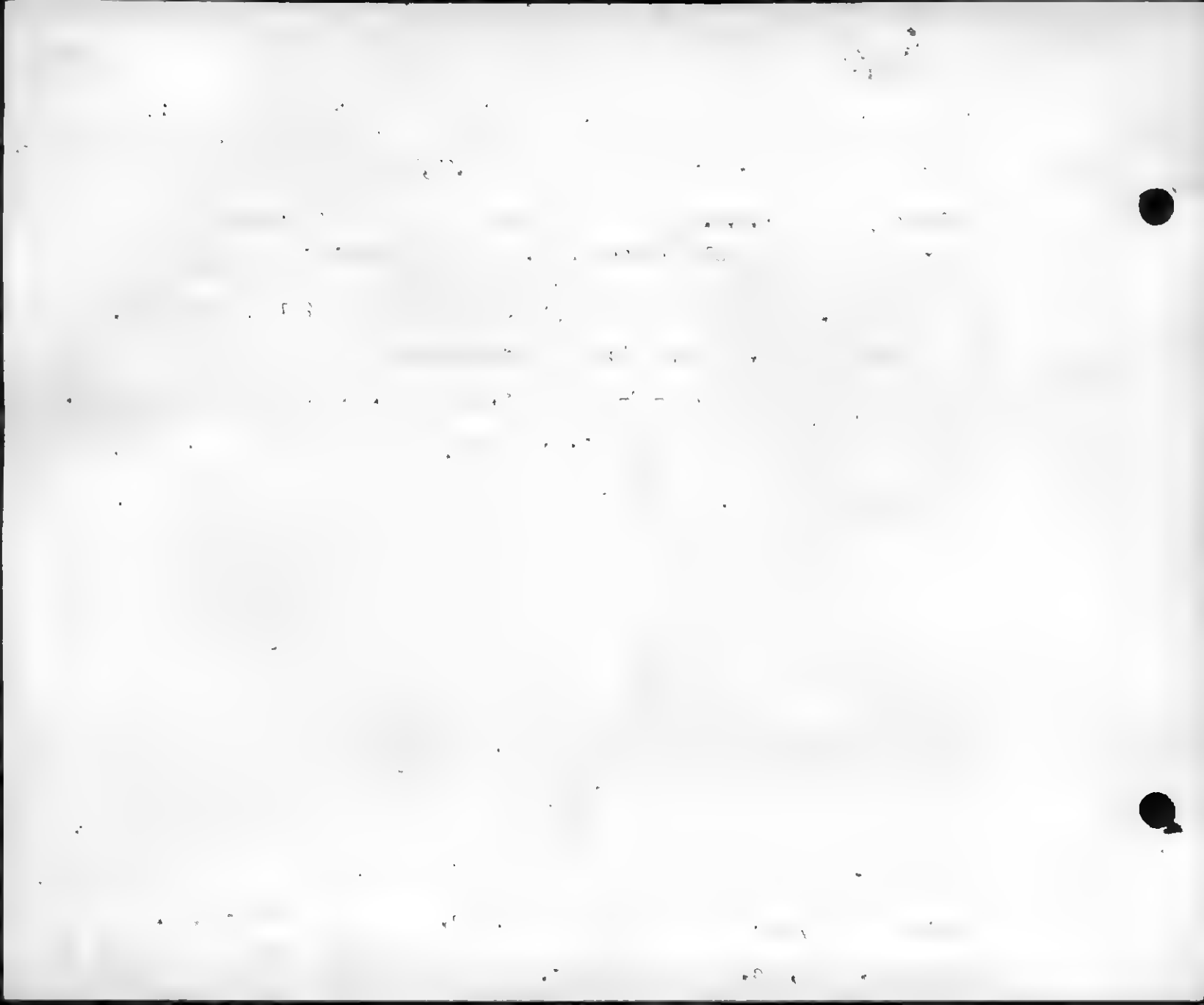
1. DECEASED-NAME (Type or print)		First EMMA	Middle M.	Last DEIGERT	2a. DATE OF DEATH APRIL Month 4 , Day 1968		2b. HOUR 5:45 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 8, 1882		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTH-PLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, Md.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8019 BELAIR ROAD #21236	
14. FATHER'S NAME First Middle Last Joseph Tremper				15. MOTHER'S MAIDEN NAME First Middle Last Anna Kaup					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-21-7740		17. INFORMANT Address Mr. Joseph D. Deigert, Box 57, Fork, Md. 21051					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive diverticulosis DUE TO, OR AS A CONSEQUENCE OF (b) Abscess sigmoid DUE TO, OR AS A CONSEQUENCE OF (c) Peritonitis (d) Fecal fistula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 2/28/68 3/20/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction, Sigmoid perforation postco.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY lostomy HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 26, 1968 , to APRIL 4, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anibal Escobar, M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED April 4, 1968			
22d. PHYSICIAN'S NAME (Type) Anibal Escobar				22e. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-6-1968		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.			
24. FUNERAL DIRECTOR ADDRESS Lessard Funeral Home 740 Belair Rd.				25a. REC'D BY REGISTRAR APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) ANNA First Middle Last M. DEMARCO			2a. DATE OF DEATH APR Month 7 Day 68 Year		2b. HOUR 7:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Feb. 27, 1882		6. AGE (In years last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Indiana	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore		Md
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 211 Dumbarton Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 211 Dumbarton Rd.	
14. FATHER'S NAME First Middle Last Hugh J. Fitzpatrick		15. MOTHER'S MAIDEN NAME First Middle Last Mary Mullin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-30-0940	17. INFORMANT Address Mrs. Amelia E. Donohue 211 Dumbarton Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 41 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION MIN. DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from JUL , 19 65 , to APR , 19 68 , that (I) (we) last saw the deceased alive on 6 APR , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Salvatore R. Donohue M.D.			22c. DATE SIGNED 7 APR. 68	22d. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE (M.D.)	
22e. ADDRESS 7418 STANMORE CT, BALTO. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/10/68	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, inc. 5305 Harford Rd.			25a. REC'D BY REGISTRAR DATE APR 9 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MD218
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last John Irvin DENBOW, Sr.			2a. DATE OF DEATH Month Day Year 4 21 68			2b. HOUR 5:15 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 10/29/11		6. AGE (in years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Tavern	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3308 Woodstock Ave.							
14. FATHER'S NAME First Middle Last Samuel Denbow				15. MOTHER'S MAIDEN NAME First Middle Last Sena Martin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 212-09-1454		17. INFORMANT Address Mildred E. Denbow, 3308 Woodstock Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis and congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Multiple hepatic abscesses DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of head of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardiovascular disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/27 , 19 68 , to 4/21 , 19 68 , that (I) (we) last saw the deceased alive on 4/21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John E. Adams				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/21/68	
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.				22e. ADDRESS 6701 N. Charles Street			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE 4-25-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or Town) (County) (State) Harford Co., Md.	
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.				25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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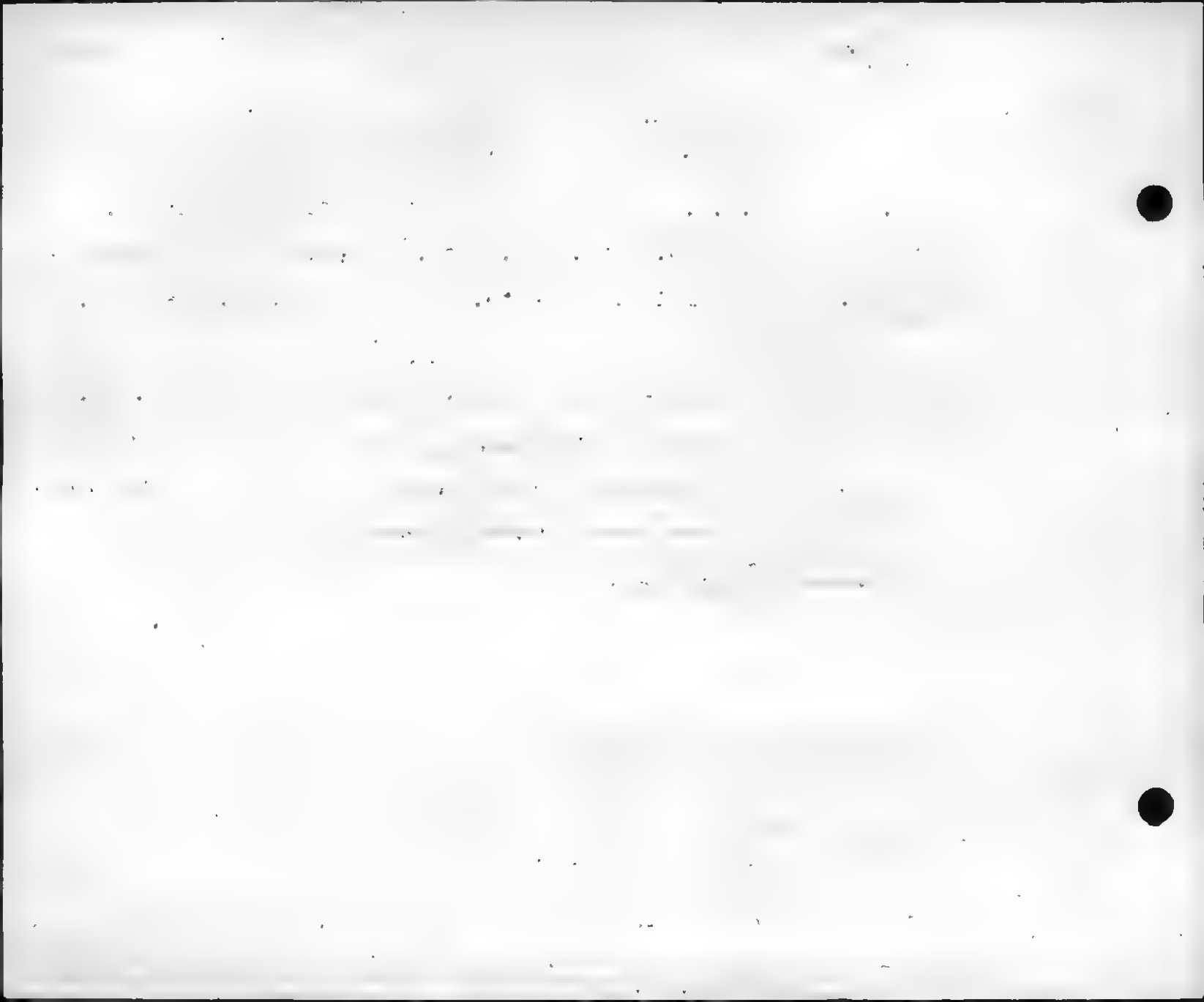
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05223

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Mary, E. DeWitt					4 4 68			
3 SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	White	12/13/90			77 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		12b. K IND OF BUSINESS OR INDUSTRY		
Ill.	U.S.A.			Baltimore, Balto.		homemaker		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. K IND OF BUSINESS OR INDUSTRY		
Baltimore		Balto. Cnty. Gen. Hosp.		housewife		homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Md.		Balto.	Balto.		3505 St. James Rd.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
William NMI Jones					Julia NMI Price			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		332-14-7400		BCGH Hosp. Record - 5401 Old Ct. Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u>								Months -
402X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiomegaly 525 gm</u>								YRS - Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Shunt arteriole nephrosclerosis</u>								YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>pulmonary atelectasis</u>								
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>11-PM, 4-49-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Angelita A. Topacio</u>				DEGREE ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED <u>4-4-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>ANGELITA A - TOPACIO</u>				22e. ADDRESS <u>BCDH</u>				
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/10/68	Mt. Sterling City Cem.		Mt. Sterling, Illinois			
24. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Road</u> <u>Baltimore, Md. 21212</u>				25a. REC'D BY REGISTRAR DATE <u>APR 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



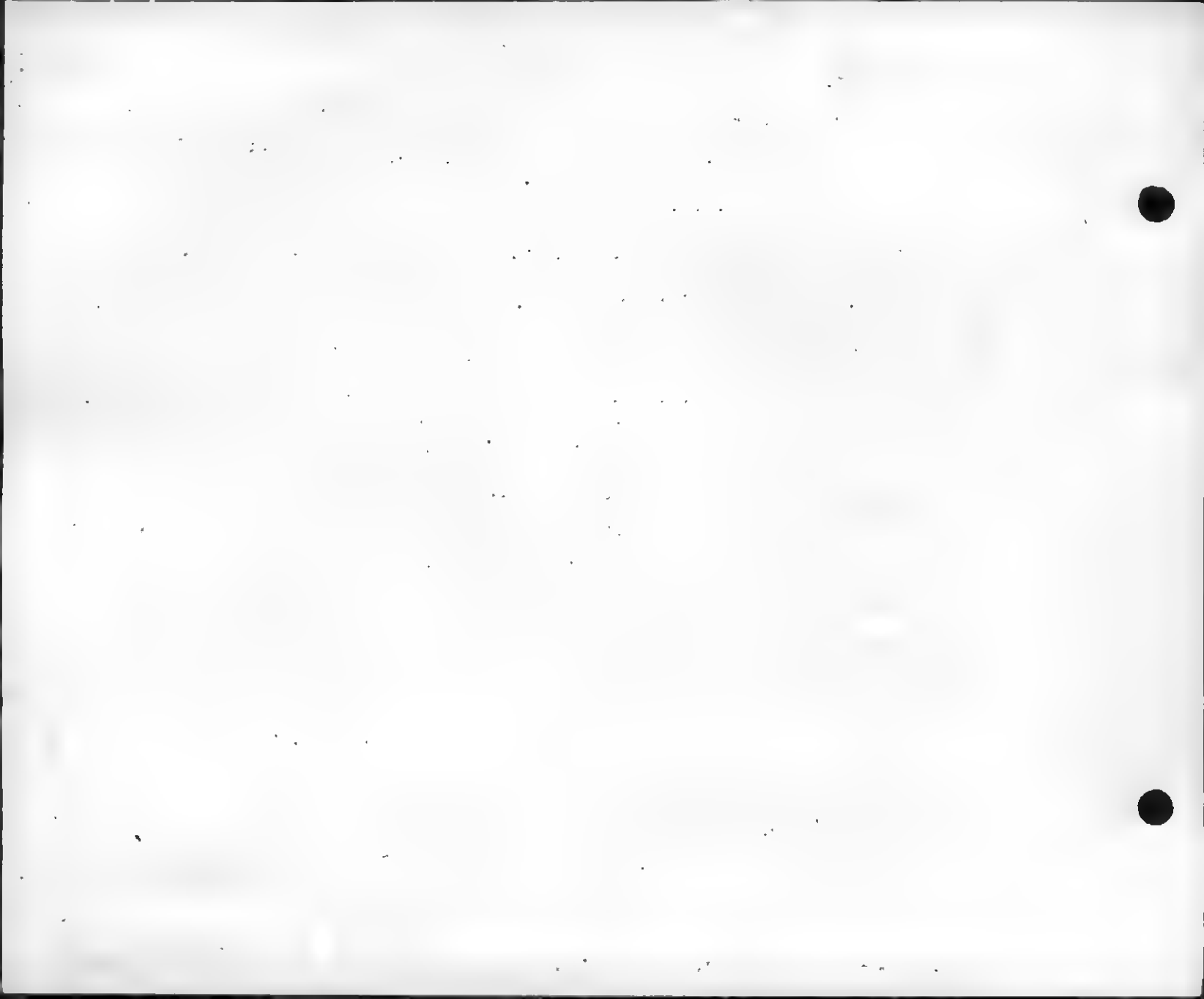
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000).

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Ellen C. Dolan			2a. DATE OF DEATH April Month 13 Day 1968 Year			2b. HOUR M				
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH June 23, 1893		6. AGE (In years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8356 Loch Raven Blvd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Towson			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Owen Craig			15. MOTHER'S MAIDEN NAME First Middle Last ??							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO R.R.Ret.			17. INFORMANT Address C. Vincent Dolan, 8356 Loch Raven Blvd. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. f1d4 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema of lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden ? 2 weeks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10/27 , 1967 , to 4/13 , 1968 , that (I) (we) last saw the deceased alive on 4/11 , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Joseph S. Blum MD						DEGREE MD		22c. DATE SIGNED 4/15/68		
22d. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD						22e. ADDRESS 115 N. CALVERT ST				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-16-1968		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or Town) (County) (State) Cockeysville, Balto, Md.				
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, Md.						25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

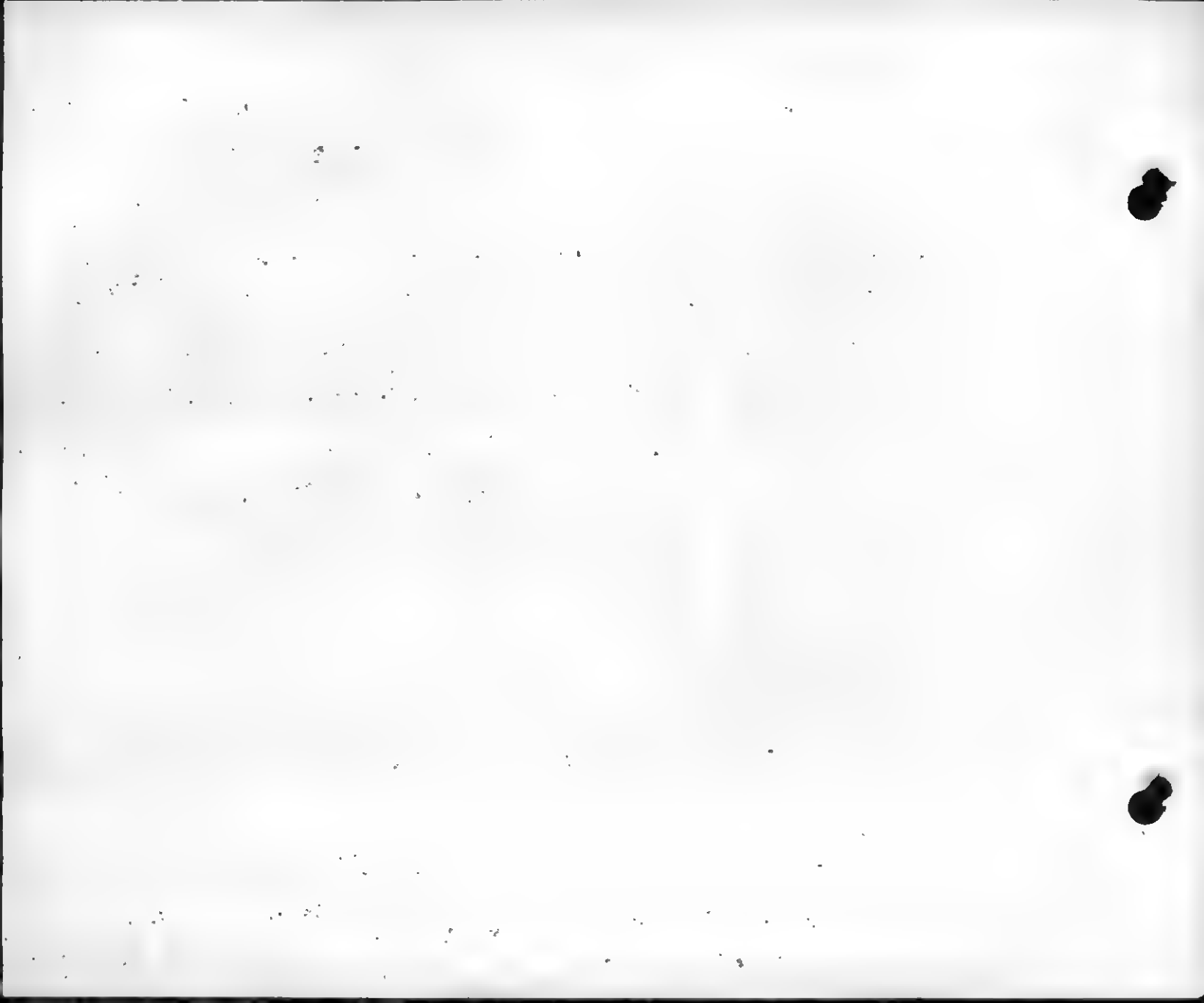
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30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Irene Ida Doran			2a. DATE OF DEATH Month Day Year 4 29 1968			2b. HOUR 2:22 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 19, 1892		6. AGE (in years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) Joppa, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, County Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Casefile		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Carl August Anderson		15. MOTHER'S MAIDEN NAME First Middle Last Barbara Sophia Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 219-42-5170		17. INFORMANT Address Barbara D. Johnson, 312 Phila Rd, Joppa, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>20 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 1958</u> , to <u>April 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (the) (do not) view the body after death.							
22b. SIGNATURE <u>Dr. Littleton</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4-29-68</u>	
22d. PHYSICIAN'S NAME (Type) Dr Littleton				22e. ADDRESS <u>1012 Old Northpoint Rd</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 2, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Joppa Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McCombs & Son, Baltimore, Md.</u>				25a. RECEIVED BY REGISTRAR DATE <u>MAY 01 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

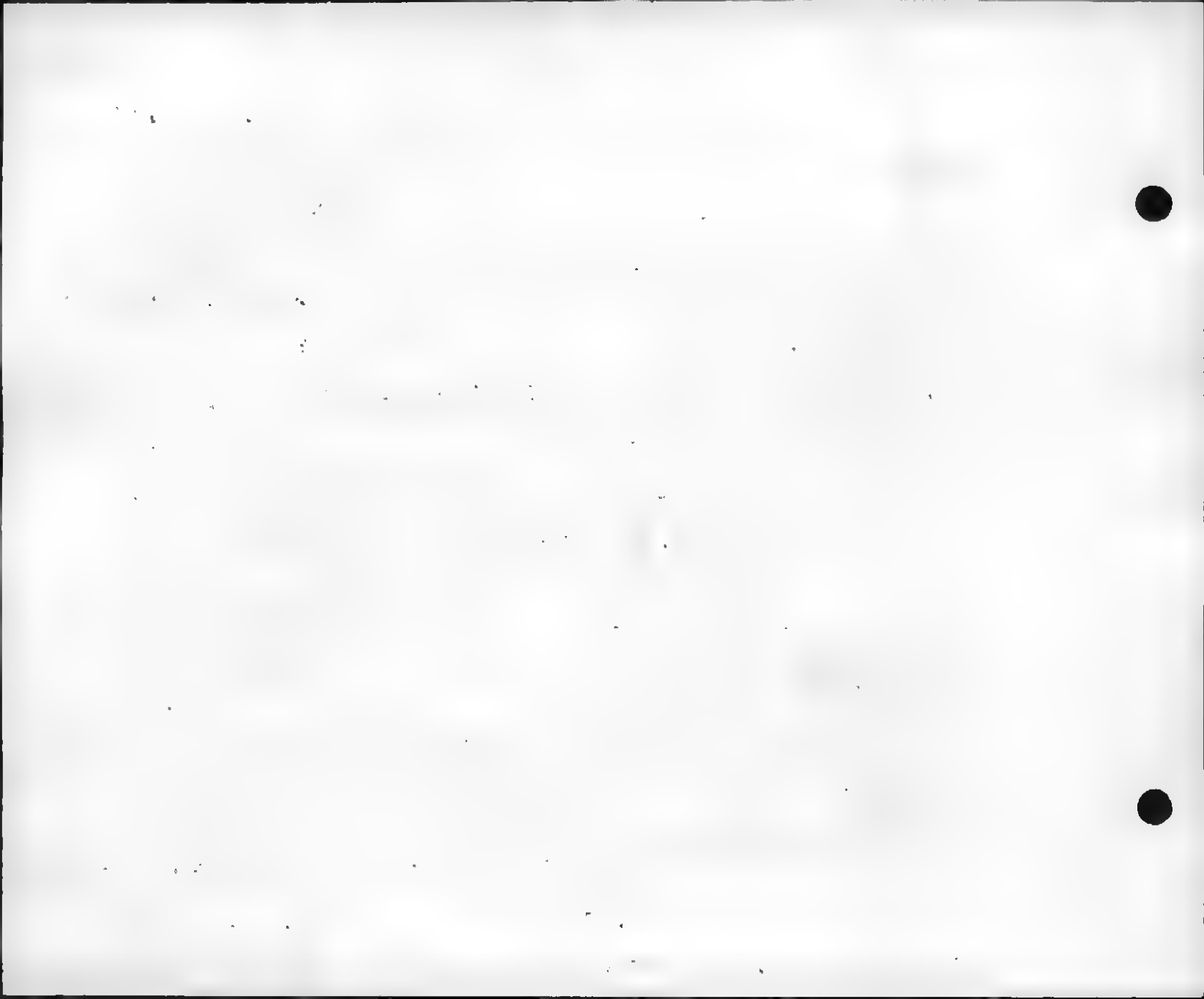
MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Sarah			A DUVALL			Month Day Year April 5, 1968			8:15AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		May 4, 1887			80 YRS		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Virginia			U.S.A.						Baltimore,				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			ST. JOSEPH HOSPITAL			Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6600 Eastern Parkway	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Franklin P.			Jarvis			Catherine Lucretia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
No			219-12-7282			Mr George H Duvall			Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Broncho-pneumonia													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Pleural effusion													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Hodgkin paraganuloma													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
201X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
3/5/68			Intra-abdominal tumor			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State				
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>													
22a. I certify that (X) (this hospital) attended the deceased from 2/29/1968, to 4/5/1968, that (X) (we) last saw the deceased alive on 4/5/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
Rafael Hernandez, M.D.			April 5, 1968										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
George			7620 York Rd., Towson, Md. 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			4/8/68			Mt. Olivet			Baltimore, Maryland				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Leonard J Ruck Inc.			Baltimore, Maryland			APR 9 1968			Charles Judge				



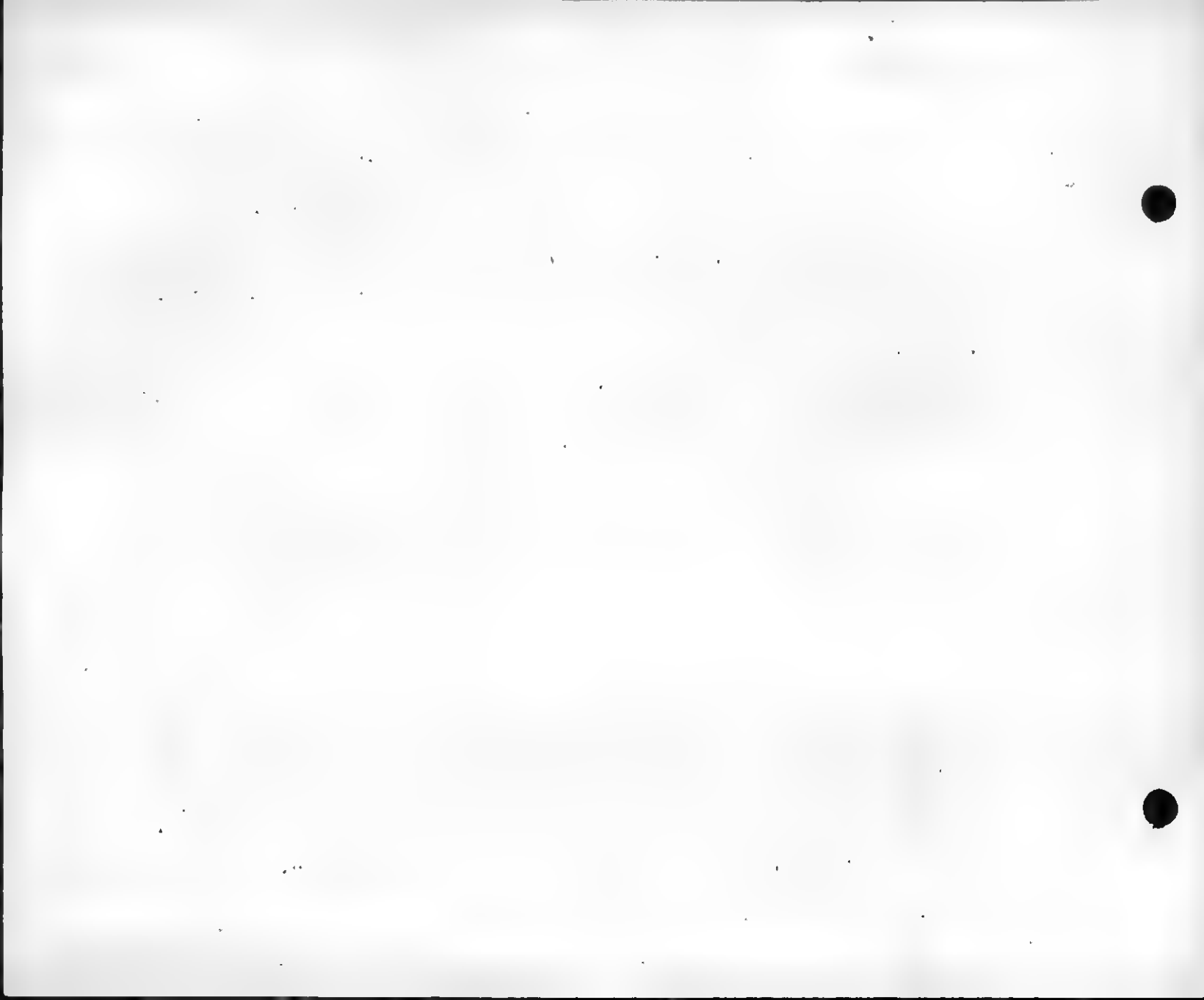
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First ANTHONY	Middle JOSEPH	Last ECKHARDT	2a. DATE OF DEATH Month Day Year APRIL 13 1968		2b. HOUR 9:15aM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH August 16, 1935		6. AGE (In years last birthday) 32 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		12b. KIND OF BUSINESS OR INDUSTRY LOAN CO	
10. CITY OR TOWN OF DEATH Towson 4	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MER		12b. KIND OF BUSINESS OR INDUSTRY LOAN CO		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1050 Foxwood Lane #21			
14. FATHER'S NAME First Middle Last ANTHONY M. ECKHARDT		15. MOTHER'S MAIDEN NAME First Middle Last P		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) UNK			
16b. SOCIAL SECURITY NO 216-32-1255		17. INFORMANT MARY ECKHARDT		Address ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office buildings, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from January 23, 1968, to April 13, 1968, that (we) last saw the deceased alive on April 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vichian Phupakdi		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED April 13, 1968			
22d. PHYSICIAN'S NAME (Type) Vichian Phupakdi, M.D.		22e. ADDRESS 7620 York Rd. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/16/68		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City or Town) (County) (State) BALTO. MD	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

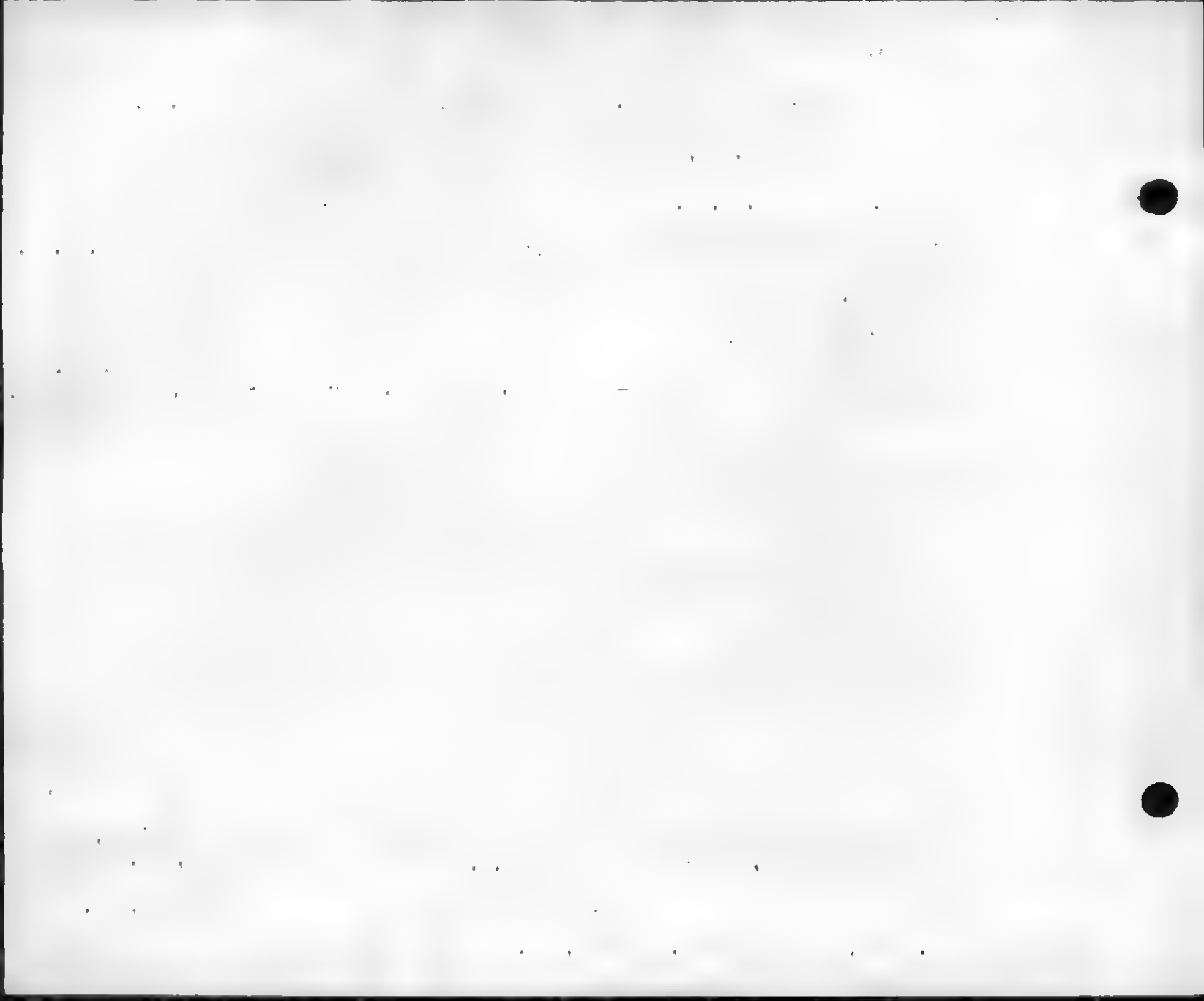


FOR STATE
HEALTH DEPT.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Lillian			J. Eichelberger			<input checked="" type="checkbox"/> Month Day Year Apr. 9, 1968			<input checked="" type="checkbox"/> 17 9 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR		8 UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Female	White	Jan. 28, 1911	57 YRS	MONTHS	DAYS	HOURS	MIN	April 9, 1968			1 34 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH			10b KIND OF BUSINESS OR INDUSTRY		
Maryland		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore			U. S. A.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Dundalk			4 Bayside Drive			Housewife			U. S. A.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Baltimore			Dundalk			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
Harry Granruth			Edith Smith			No			213-36-3074		
17 INFORMANT (Husband)			ADDRESS			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mr. Samuel D. Eichelberger, Jr.			4 Bayside Dr.			4129 H-S-C-V Disease					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION (Street or R.F.D. No. City or Town County State)					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER			6800 Mornington Rd.		
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
Melvin B. Davis						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			April 9, 1968		
						ADDRESS (Street, city, town, or county)			Dundalk, Md. 21222		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			4/12/68			Oak Lawn Cemetery			Baltimore, Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STRAR			25b REG. STRAR'S SIGNATURE		
John J. Duda, 7922 Wise Ave.			Dundalk, Md.			DATE			APR 15 1968		

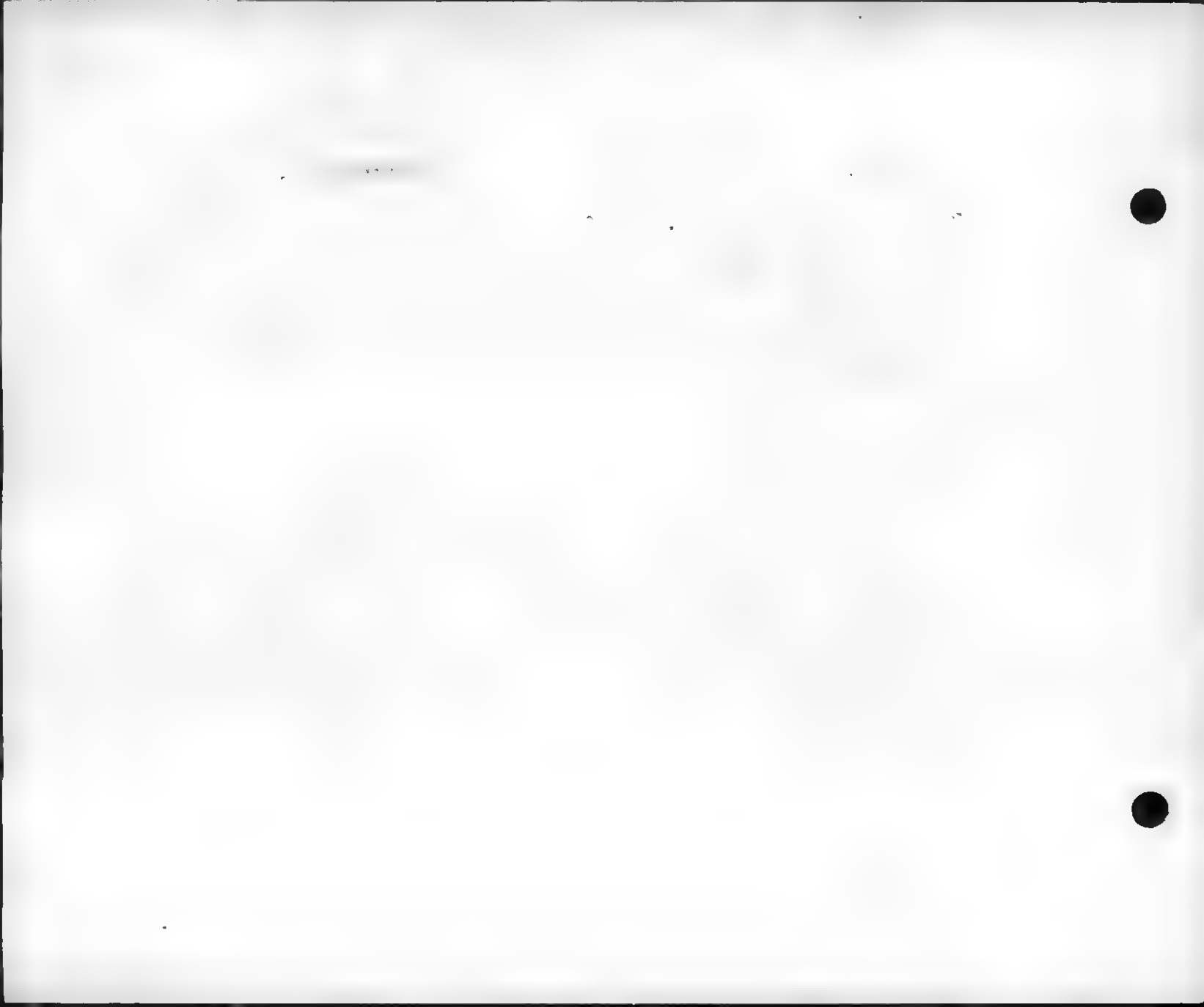


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05225
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item 9 Film G399 4/16/68 kk
 CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN Catonsville		c. LENGTH OF STAY IN TB 9 months		c. CITY OR TOWN Catonsville,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7106 Rolling Road Apt. A 27				d. STREET ADDRESS BALTIMORE, MD 21227		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) NORMA ANNA EUKER				4 DATE OF DEATH APRIL 1 1968			
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/2/1879	9 AGE (in years last birthday) 189/38 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MD		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME LEANDRO ECKEMDIA				14 MOTHER'S MAIDEN NAME SARAH ?			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.)		16 SOCIAL SECURITY NO		17. INFORMANT DAUGHTER Address 7106 ROLLING RD AUDREY L. FEASDER BALTIMORE MD 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPERTENSIVE RATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) PREMATURE VENTRICULAR CONTRACTION'S DUE TO (c) RIGHT MYOCARDIAL INFARCTION.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4/2/68						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12/26 1966 , to 4/1 1968 , that (I) (we) last saw the deceased alive on 3/23 1968 , and that death occurred at 7:40 P.M. , from causes and on the date stated above.							
22a. SIGNATURE E. KASARI'S, M.D. M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4/1/68			
22c. PHYSICIAN'S NAME (Type) E. KASARI'S, (M.D.)		22d. ADDRESS 1801 FREDERICK RD BALTO + 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/3/68	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR Wm. Fickner		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR APR 5 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

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MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST. DEATH MATED		2b HOUR	
AUDREY		LILLIAN		FEADER				Month Day Year 4-21-1968		M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year		2d. HOUR
Female	White	1-28-09		59 YRS					April 21 1968		10:10 M
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH					
Balto. Md.		U. S. A.				BALTIMORE Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Catonsville				7106-A Rolling Rd.							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.				Baltimore		Catonsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		7106-A Rolling Road	
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Alfred A. Euker				First		Middle		Last		Norma Anna	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7221											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		April 22, 1968	
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		4/23/68		London Pk		Balto. Md.					
24 FUNERAL DIRECTOR				ADDRESS		25a. RECEIVED BY REGISTRAR		25b. RECEIVED BY MEDICAL EXAMINER			
William J. Tickner				Balto. Md.		DATE MAY 10 1968		J. J. Judge			

1957

1958

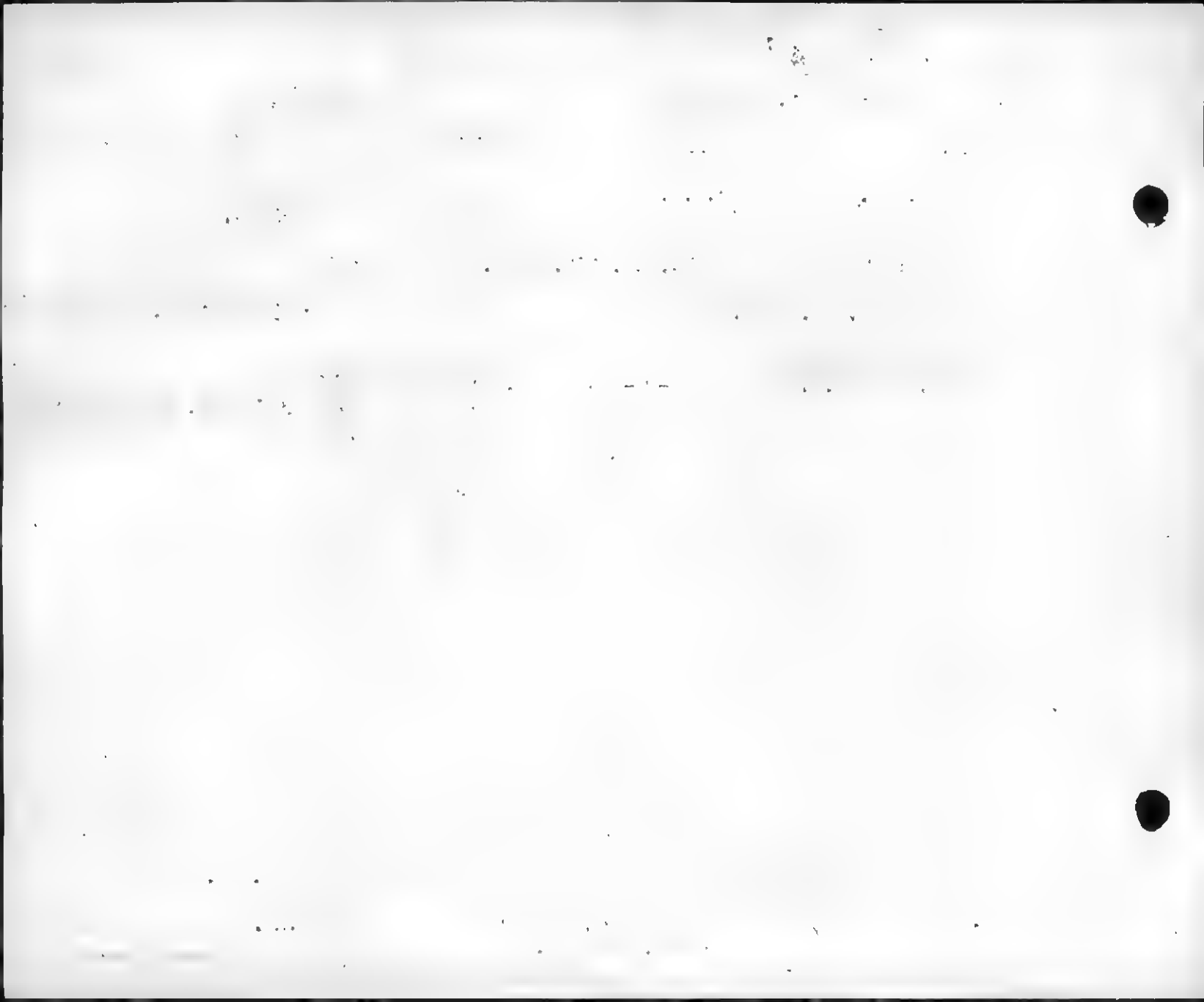
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VR 4-5-60
304A REV. 7-68

MD227
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) PHILIP A. FELICETTI		2a. DATE OF DEATH 4/13/68		2b. HOUR M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 7/31/12	6. AGE 55 years (lost 25 day) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) BALTO. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTO. Md.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) BALTO. CO. GEN. HOSP. BARBER	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE BALTO. CO.	13b. COUNTY RANDALLSTOWN	13c. CITY OR TOWN BALTO. CO.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8803 SONYA RD. RANDALLSTOWN	
14. FATHER'S NAME First Middle Last ANTONIO FELICETTI	15. MOTHER'S MAIDEN NAME First Middle Last GRACE LOMBARDI		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give dates of service)		
16b. SOCIAL SECURITY NO. 220-05-0031		17. INFORMANT MRS. MARGUERITE FELICETTI Address 8803 SONYA RD. RANDALLSTOWN			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 109 DUE TO, OR AS A CONSEQUENCE OF A.S.H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/6 , 19 66 , to present , 19 68 , that (I) (we) last saw the deceased alive on 3/7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bernard Bergen M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/15/68	
22d. PHYSICIAN'S NAME (Type) BERNARD BERGEN		22e. ADDRESS 6721 RIESERTOWN RD. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/16/68	23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTO. Md.		
24. FUNERAL DIRECTOR Frank Della Croce	24b. ADDRESS 322 S. HIGH ST.		25a. REC'D BY REGISTRAR ADD 16 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	

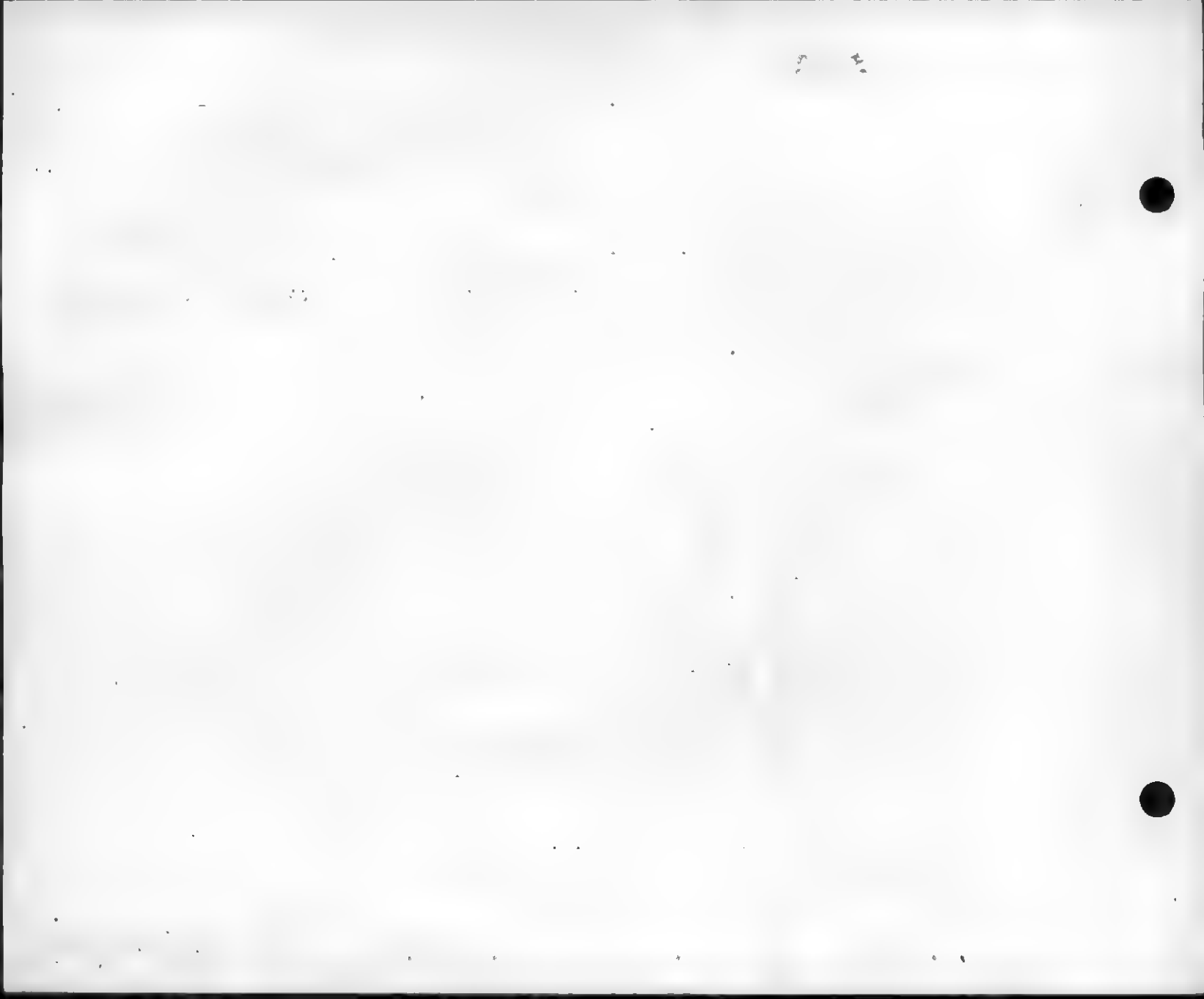


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MIDDLE										LAST									
1. DECEASED NAME (Type or Print) FRANCIS Preston FENTON										2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 4-27 1968 1:05 PM									
3. SEX Female		4. RACE White		5. DATE OF BIRTH		6. AGE (In years last birthday) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year April 27, 1968				2d. HOUR 1:05 PM			
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH BALTIMORE				Md			
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B. M. C.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) STATE Md.				13b. COUNTY Baltimore				13c. CITY OR TOWN Brooklandville				13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER Valley Rd. "Brandonwood"			
14. FATHER'S NAME First Middle Last Harry J. Carroll						15. MOTHER'S MAIDEN NAME First Middle Last Susan Preston													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b. SOCIAL SECURITY NO. (If yes give war or dates of service)						17. INFORMANT ADDRESS Foster T. Fenton Above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Blunt injuries of trunk DUE TO, OR AS A CONSEQUENCE OF (b) 187X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:52 AM 4-27 1968						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Jumped or fell from 2nd floor							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Sheppard Pratt Hospital						21f. LOCATION Street or R.F.D. No City or Town County State Towson Baltimore Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Charles S. Springate						M.D. Charles S. Springate, M.D.						22b. DATE SIGNED April 28, 1968							
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
						ADDRESS (Street, city, town, or county)													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4-29-68				23c. NAME OF CEMETERY OR CREMATORY Druid Ridge				23d. LOCATION (City or Town) (County) (State) Pikesville Md.							
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						ADDRESS 4905 York Rd. Balto.						25a. REC'D BY REGISTRAR MAY 2 1968				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

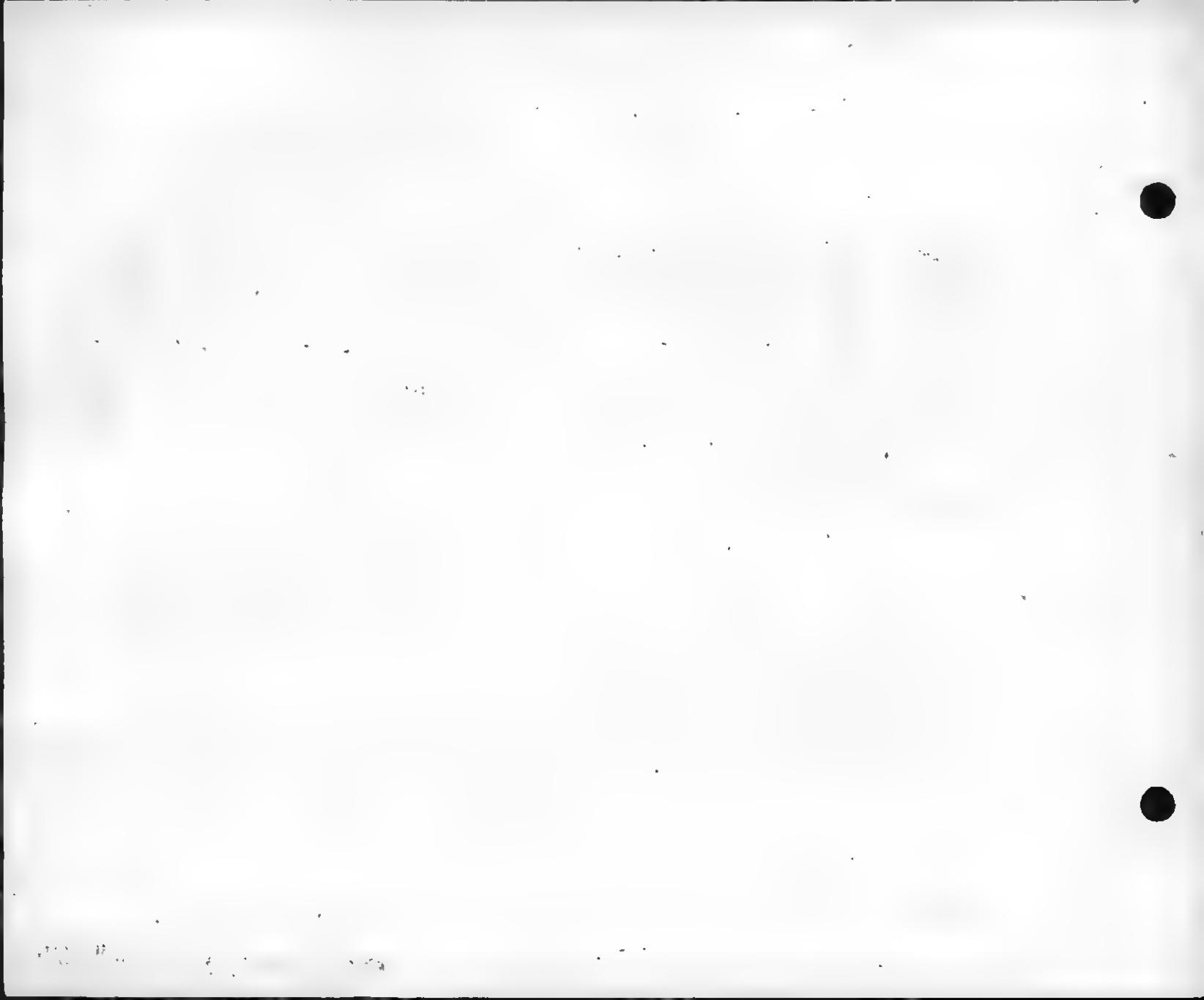
State md

VR A15 (4)
30A REV 1/68

MD225
00225
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05234

1. DECEASED-NAME (Type or print) JAMES NELSON FESMYER			2a. DATE OF DEATH Month 4 / Day 10 / Year 1968			2b. HOUR 11 A.					
3. SEX male		4. RACE white		5. DATE OF BIRTH 7/3/1890		6. AGE (In years last birthday) 77 YRS		IF UNDER 1 YEAR MONTHS 77 DAYS 77 HOURS 77 MIN			
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md					
10. CITY OR TOWN OF DEATH Mount Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumber			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Queen Annes Centerville			13c. CITY OR TOWN Centerville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 101 S. Liberty St.	
14. FATHER'S NAME First Joseph Middle Fesmyer Last Fesmyer			15. MOTHER'S MAIDEN NAME First Mary Catherine Middle Harper Last Harper								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 216-12-1469			17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung. 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 7/22/1968 , to 4/10/1968 , that (I) (we) lost the deceased alive on 4/10/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William Newcomer									22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.									22e. ADDRESS Mount Wilson, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE April 12, 1968			23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery			23d. LOCATION (City or Town) (County) (State) Centerville, Queen Annes, Md.		
24. FUNERAL DIRECTOR James H. Baiter			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE APR 16 1968		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

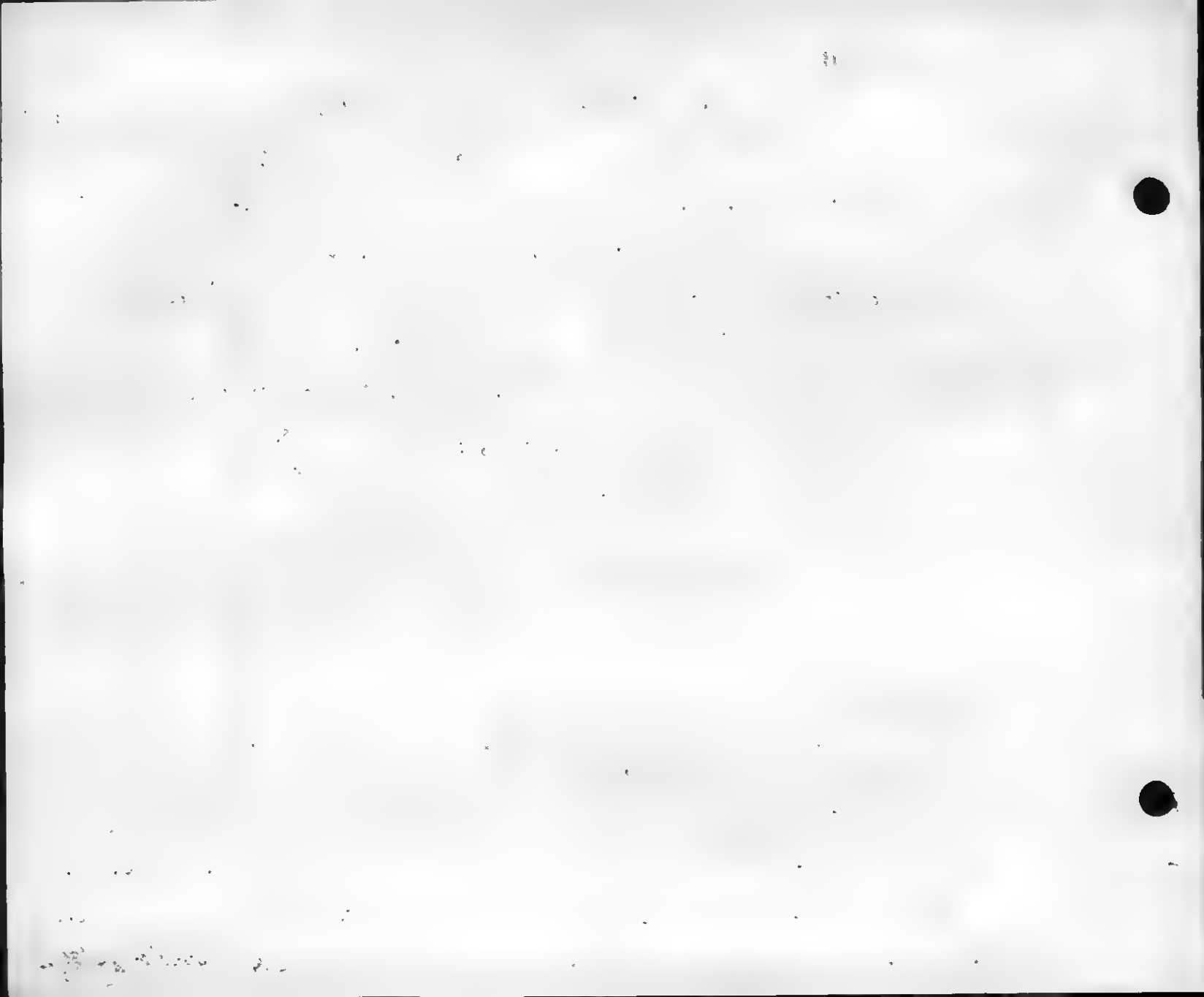
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05230

934

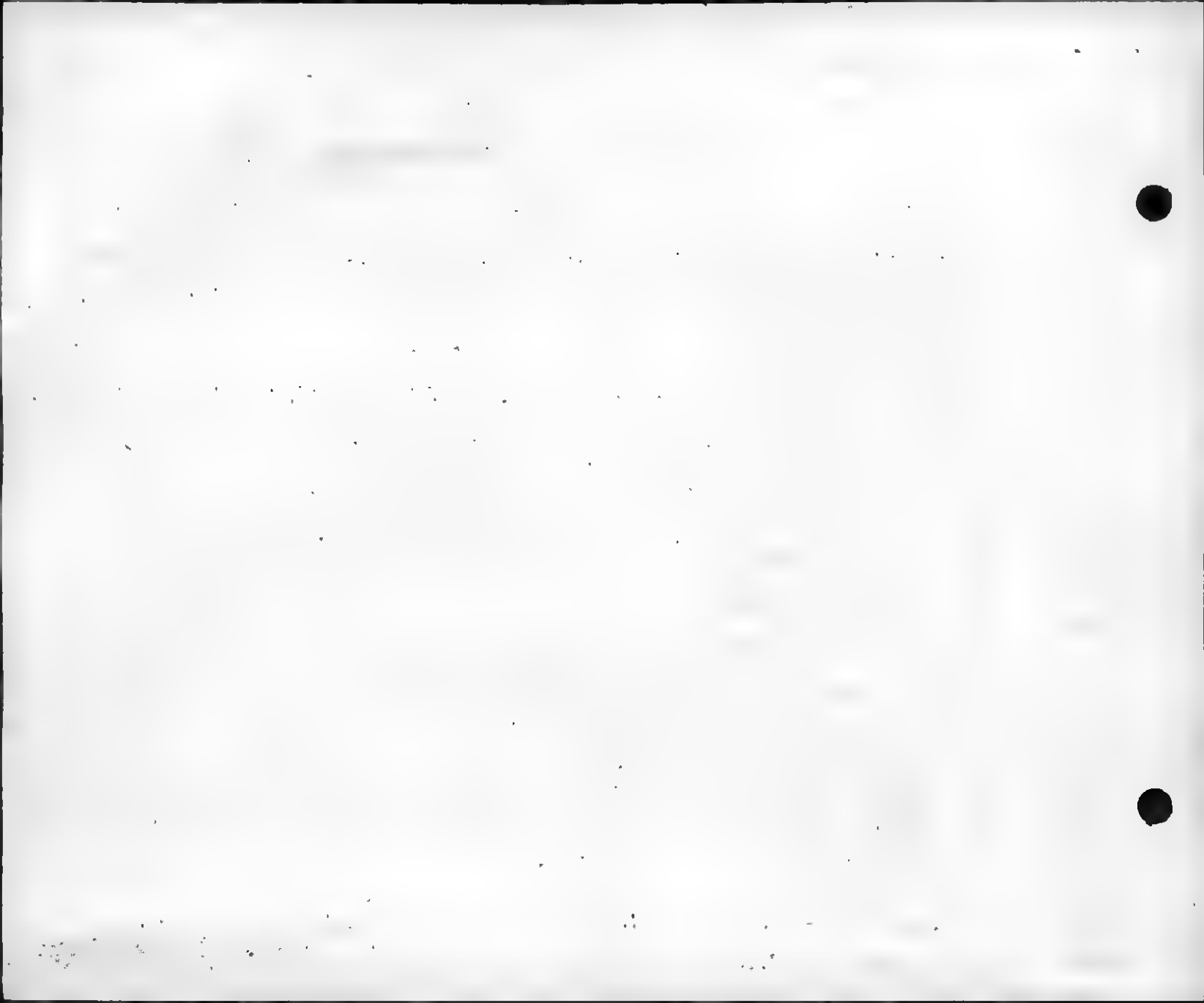
1. DECEASED NAME (Type or print) First KENNARD Middle W. Last FISHER			2a. DATE OF DEATH Month April Day 9 Year 1968			2b. HOUR 6:00 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12-8-1893		6. AGE (In years lost birthday) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 415 Overbrook Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b. KIND OF BUSINESS OR INDUSTRY 		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 415 Overbrook Road		
14. FATHER'S NAME First Howard Middle Fisher Last 				15. MOTHER'S MAIDEN NAME First Agnes M. Middle Mohrman Last 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 		17. INFORMANT Address Mrs. Marie E. Fisher, 415 Overbrook Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion, acute 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C - V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Postural Hypotension											
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) 			21f. LOCATION Street or R.F.D. No. City or Town County State 						
22a. I certify that (I) (this hospital) attended the deceased from Feb. , 19 50 , to April , 19 68 , that (I) (we) last saw the deceased alive on March 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Leo Gaver										22c. DATE SIGNED April 10, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. Leo Gaver					22e. ADDRESS 1 Mallow Hill Rd., Balto., Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-12-1968		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland				
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229					25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) HARRY		First Middle Last		2a. DATE OF DEATH Month April Day 29 Year 1968		2b. HOUR 4:15 M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH [REDACTED]		6 AGE (In years lost birthday) 78 YRS	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE County Md	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTIMORE COUNTY GEN. HOSP.		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) TAILOR		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY --- ✓		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last ABRAHAM FLAY		15 MOTHER'S MAIDEN NAME First Middle Last SARAH ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 218-32-5890		17. INFORMANT Address MRS. DOROTHY GROSSMAN, 5905 PARK HEIGHTS AVE.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COMPLETE HEART BLOCK 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROTIC HEART DISEASE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 28, 1968 to April 29, 1968 , that (I) (we) last saw the deceased alive on April 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Josefina T. Naraval MD				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 29, 1968	
22d. PHYSICIAN'S NAME (Type) JOSEFINA T. NARAVAL, MD				22e. ADDRESS BALTIMORE COUNTY GEN. HOSP.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-30-68		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR MAY 2 1968		25b. REG. STAMP SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



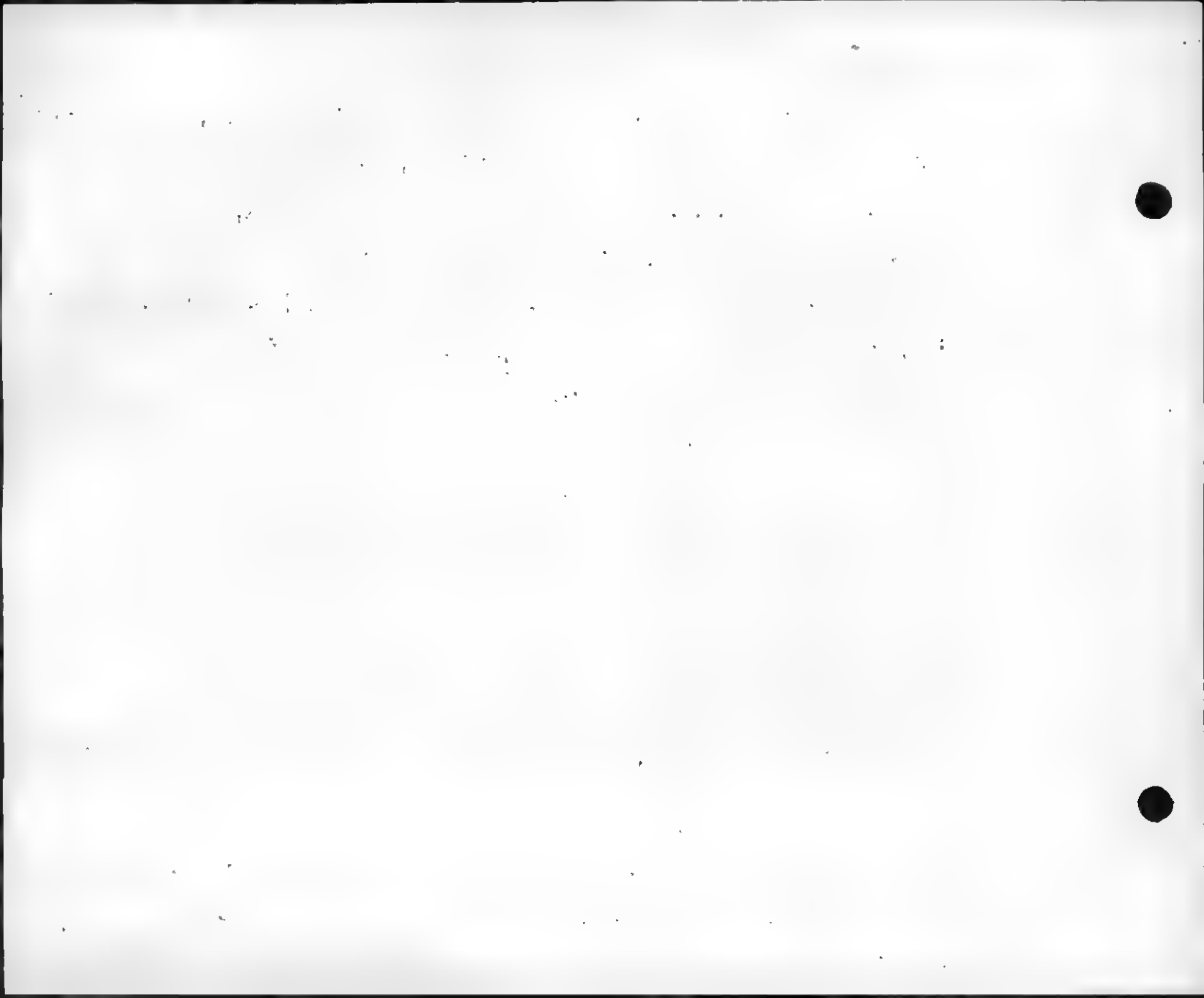
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VR A15 (4)
30M REV 1/68

DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
BEULAH		A.		FOWLER	APRIL 29, 1968		4:00 PM
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
FEMALE	NEGRO		JUNE 14, 1904		63 YRS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		U.S.A.		BALTIMORE, Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON		ST. JOSEPH HOSPITAL		HOMEMAKER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER	
MARYLAND				BALTIMORE		717 E. 22nd ST. #21218	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
William Montford				Jane Snowden			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes, no, or unknown		215-32-2794					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.							
IMMEDIATE CAUSE (a) Uremia							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Hepatic failure							
DUE TO, OR AS A CONSEQUENCE OF							
(c) Endometrial carcinoma - Stage IV							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
1121							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from APRIL 24, 1968, to APRIL 29, 1968, that (X) (we) lost saw the deceased alive on APRIL 29, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Jaime Punzalan						4-29-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Jaime Punzalan, M.D.				7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Cremation		May 4, 1968		Mt. Calvary Cemetery		A.A. County, Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. RECEIVED BY REGISTRAR	
Robert Williams				1711-03 N. Line St 21213		MAY 1 1968	
						25b. REGISTRAR'S SIGNATURE	
						Charles Judge	



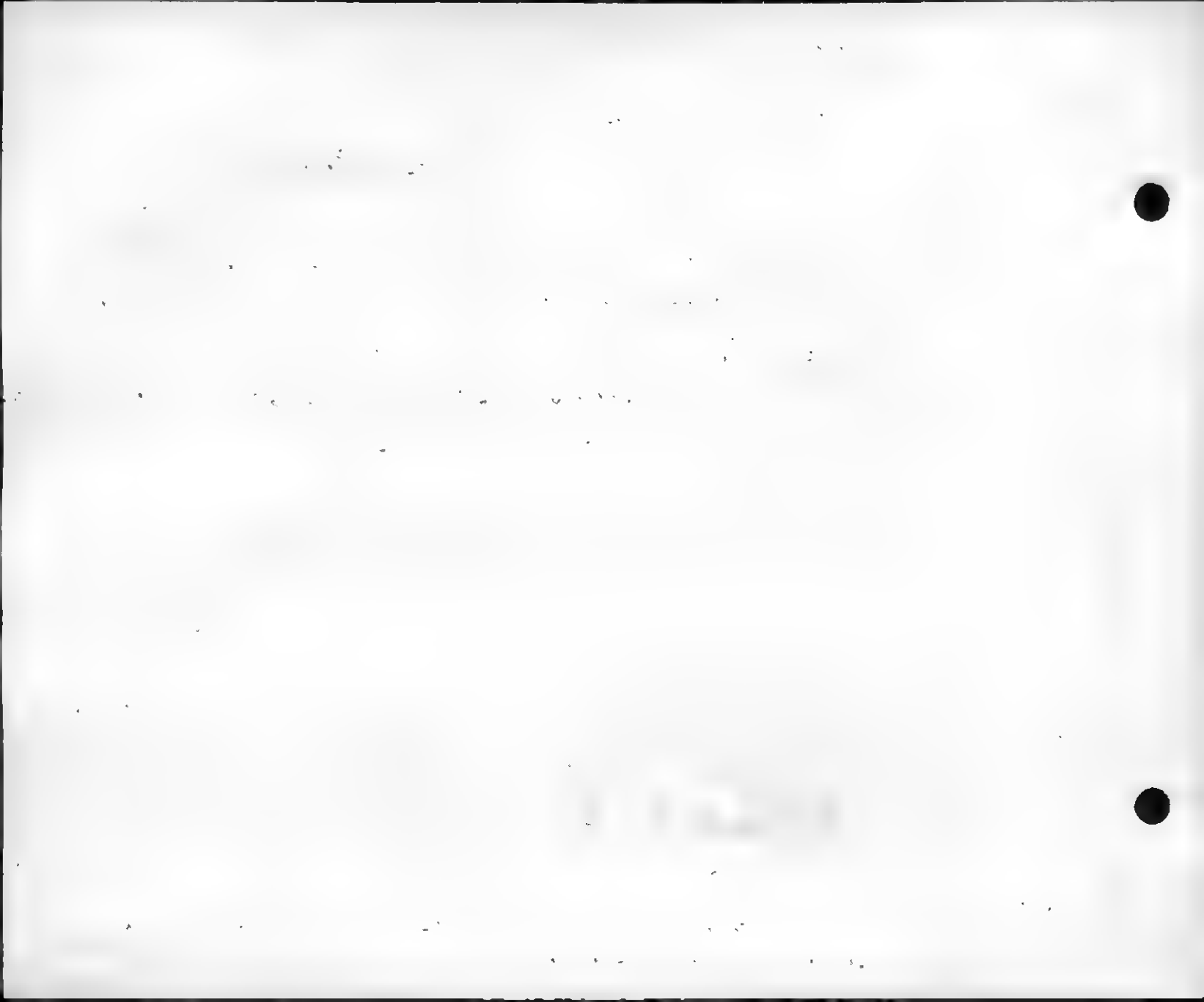
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MD 237
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Myrtle Kathryn France			2a. DATE OF DEATH Month Day Year 4 9 68		2b. HOUR 7:45 PM
3 SEX Female	4. RACE Cau	5. DATE OF BIRTH 2/28/1943/28/04		6. AGE (in years last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk, Dept. Store		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3207 Bayonne Ave.	
14. FATHER'S NAME First Middle Last George R. McGinnity		15. MOTHER'S MAIDEN NAME First Middle Last Catherine Lampe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 214-30-4696		17. INFORMANT Address Mrs. Doris Buckler, 8725 Satyr Hill Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast with metastases 114x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 17					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 9, 1968, to April 9, 1968, that (I) (we) last saw the deceased alive on April 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Breiteneker, M.D.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/10/68	
22d. PHYSICIAN'S NAME (Type) R. Breiteneker, M.D.		22e. ADDRESS 6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/13/68	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard G. Ruck, Inc., Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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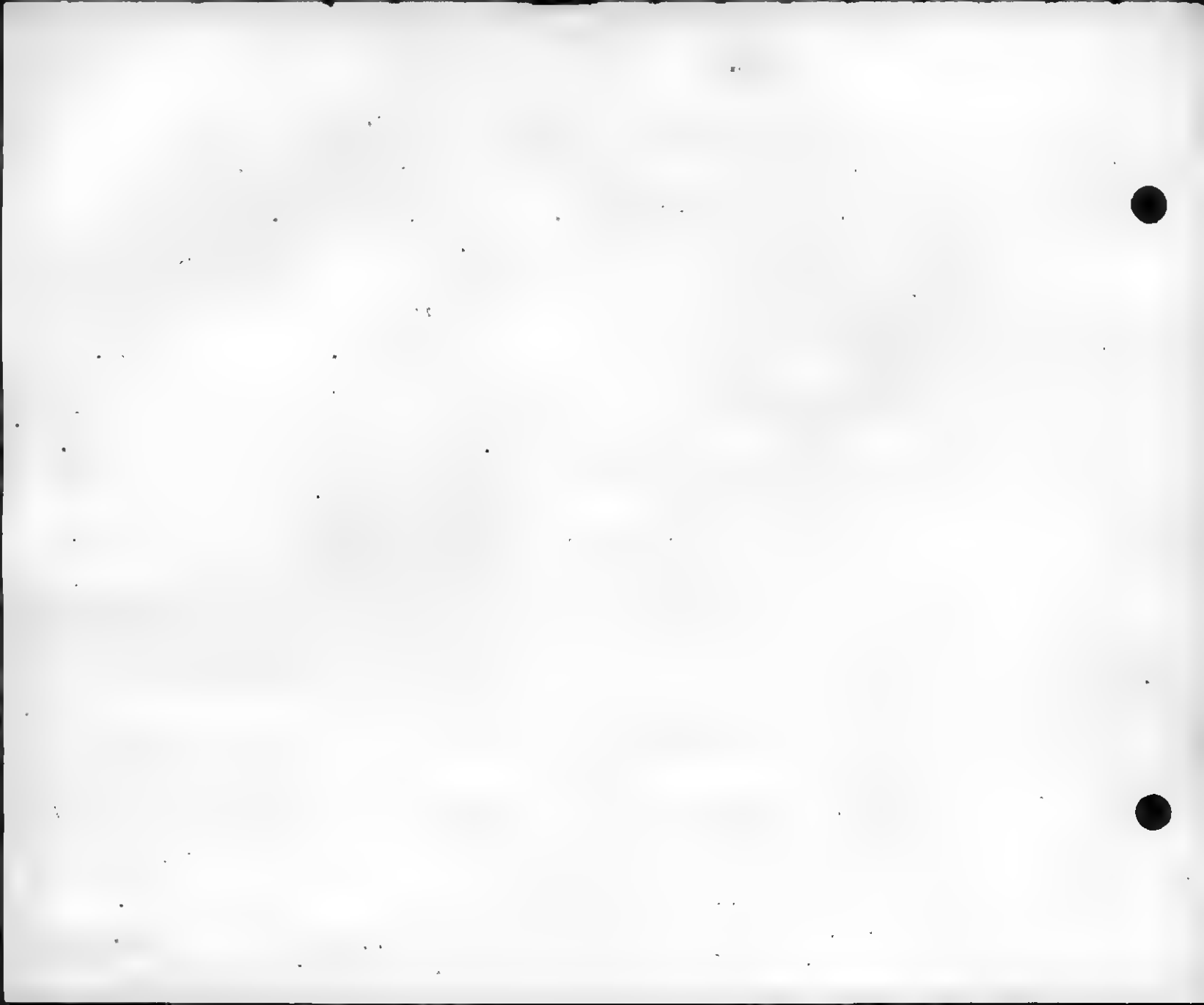
VR A15 (4)
20M 1/65

1

25234

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Pikesville, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17 Hawthorne Ave., Pikesville 8, Md.</u>		d. STREET ADDRESS <u>17 Hawthorne Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Jane</u> Last <u>Fritz</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1872</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Roxbury, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Musser</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Rowell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Adeline Valentine</u>		Address <u>Pikesville, Md.</u> <u>17 Hawthorne Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> (SCOR RATE 10 YEARS) 4/27 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC C.V. DISEASE</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>48</u> , to <u>APRIL 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Nov. 15</u> , 19 <u>67</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>APRIL 16, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN E. STROBEL</u>		22d. ADDRESS <u>FEISTERS-OWN MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 19, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		25a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>Pikesville 8, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	
DATE <u>APR 24 1968</u>			

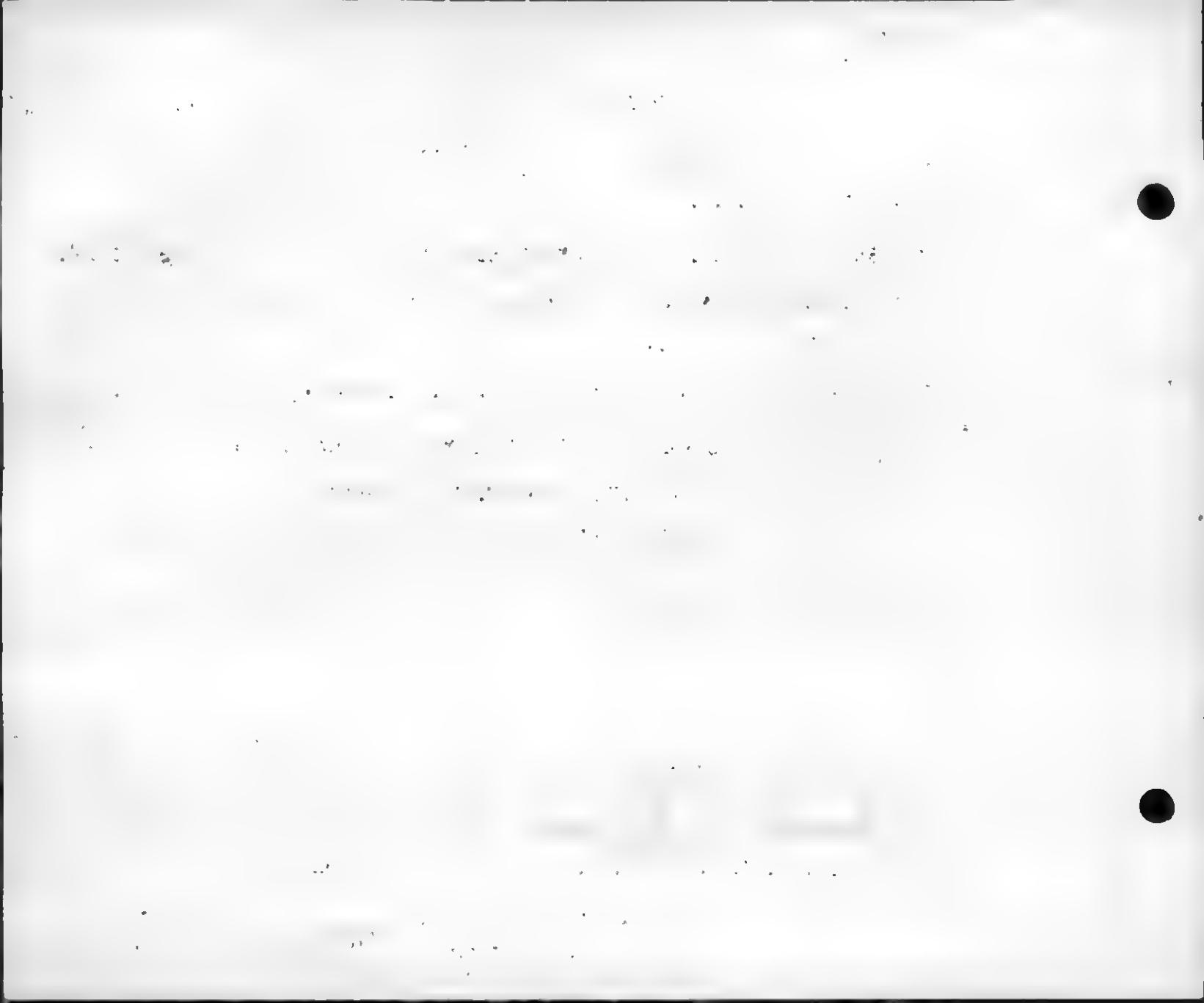


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4-6 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First HOWARD		Middle EDWARD		Last FRYE		2a. DATE OF DEATH Month 4 Day 24 Year 1968			2b. HOUR 10:50 PM
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 6/7/10			6. AGE (In years last birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md.			
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADMINISTRATION HOSPITAL			12a. USJA. OCCUPATION (Kind of work done during most of work on life, even if retired) TRUCK DRIVER			12b. KIND OF BUSINESS OR IND. STRY BALTO COUNTY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN DUNDALK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 GOLGATE AVENUE		
14. FATHER'S NAME First HOWARD Middle FRYE Last FRYE			15. MOTHER'S MAIDEN NAME First SABINA Middle DAVIS Last DAVIS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown YES (If yes give war or dates of service) WW II			16b. SOCIAL SECURITY NO 216 03 79 69			17. INFORMANT Address CLIN.REC.VA HOSPITAL, FT HOWARD, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST WITH ACUTE CORONARY OCCLUSION, POSSIBLE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1209												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SCURVY												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (b) this hospital attended the deceased from 3/16/68 , 19____, to 4/24/68 , 19____, that (i) (we) last saw the deceased alive on 4/24/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) view the body after death.												
22b. SIGNATURE Ahmed Kuttly			22c. DATE SIGNED 4/25/68			22d. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M.D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME			25a. REC'D BY REGISTRAR DATE APR 29 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						
2112 DUNDALK AVE. BALTIMORE, MD.												



MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05236

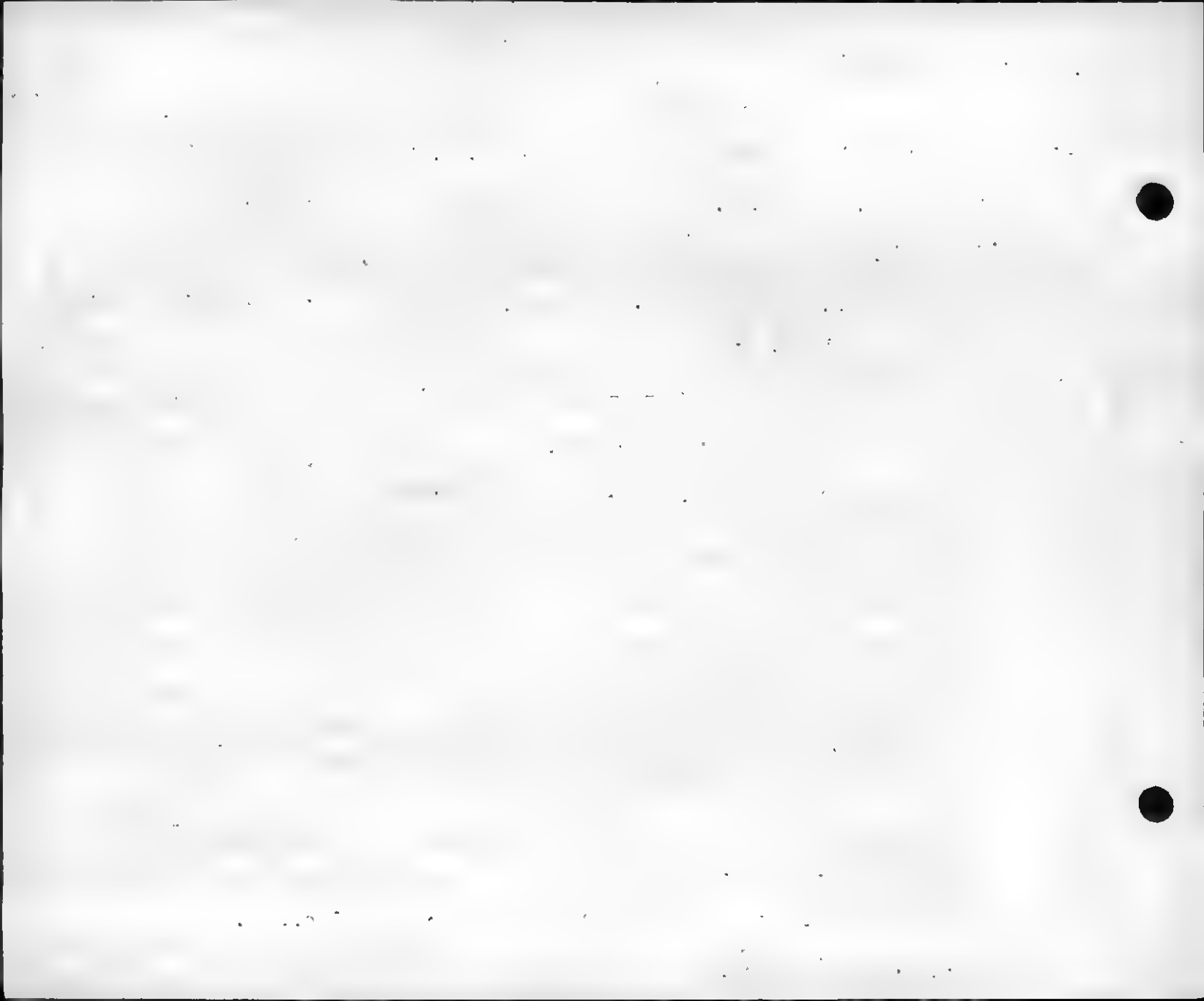
05236

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M.	
Katherine Sarah Gaffney					April 5, 1968		2:10	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
female	white		Oct. 1, 1892		75 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Md.		U. S.				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		SPRING GROVE STATE HOSP.		housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Balto.		Balto.				215 S. Augusta Avenue
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
C. Lee Brown				Sarah Agnes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
		218-22-7865		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure.</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <u>Oct. 8, 1964</u> to <u>April 5, 1968</u> , that (1) (we) last saw the deceased alive on <u>April 5, 1968</u> , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)				
<i>[Signature]</i>		4/5/68		Dr. Paul L. Machado				
22e. ADDRESS		22f. ADDRESS						
SPRING GROVE STATE HOSPITAL		Baltimore, Maryland 21228						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4-6-68		New Cathedral Cemetery		Balto., Md.		
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
4101 Edmondson Avenue		APR 9 - 1968		<i>[Signature]</i>				
Witzke Funeral Directors, Balto., Md. 21229								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION



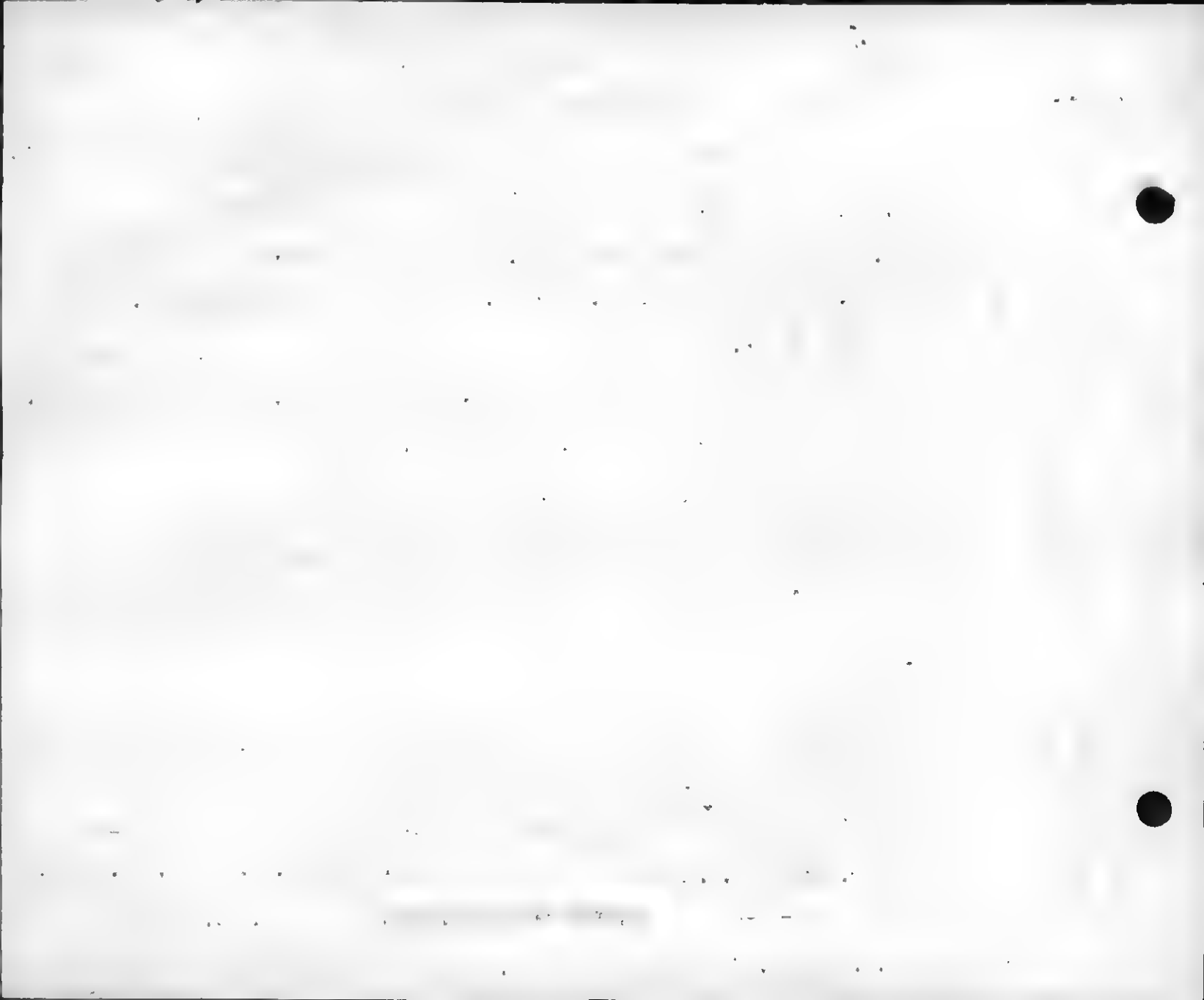
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Item 6 Film G399 11/15/68 KK
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Thomas			First Thomas Middle Arlington Last Gambrill			2a. DATE OF DEATH Month April Day 8 Year 1968			2b. HOUR 4 p M					
3 SEX Male			4 RACE White			5. DATE OF BIRTH June 29, 1905			6 AGE (In years last birthday) 62 63 YRS			7 UNDER 1 YEAR MONTHS 63 DAYS 63 HOURS 63 MIN 63		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md		
10. CITY OR TOWN OF DEATH Balto. 34			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1909 Oakdale Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor			12b. KIND OF BUSINESS OR INDUSTRY Steel					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Balto. 34			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 7909 Oakdale Ave.		
14. FATHER'S NAME First William Middle B. Last Gambrill			15. MOTHER'S MAIDEN NAME First Mary Middle Kelly Last Kelly											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213 07 3422			17. INFORMANT Mrs. Margaret Gambrill			Address 7909 Oakdale Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, Generalized DUE TO, OR AS A CONSEQUENCE OF (c) ± 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes -		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42u None														
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If other, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 13 Month Nov Day 19 P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. 7425 Harford Road. City or Town Balto. County Co. State Md.								
22a. I certify that (I) (this hospital) attended the deceased from 11 Jan, 1957 , to 8 April, 1968 , that (I) (we) lost saw the deceased alive on 13 Nov 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Edward L. Molz			DEGREE Dr. Edward L.J. Molz			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-9-68					
22d. PHYSICIAN'S NAME (Type) Dr. Edward L.J. Molz			22e. ADDRESS 7425 Harford Road. Balto. Md. 21214											
23a. BURIAL, CREMATION, REMAINS Burial			23b. DATE 4-10-68			23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEMETERY			23d. LOCATION (City or Town) (County) (State) Balto. Co. Maryland					
24. FUNERAL DIRECTOR Wm. E. Johnson.			ADDRESS 8521 Loch Raven Blvd. 21204			25a. RECEIVED BY REGISTRAR APR 11 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					



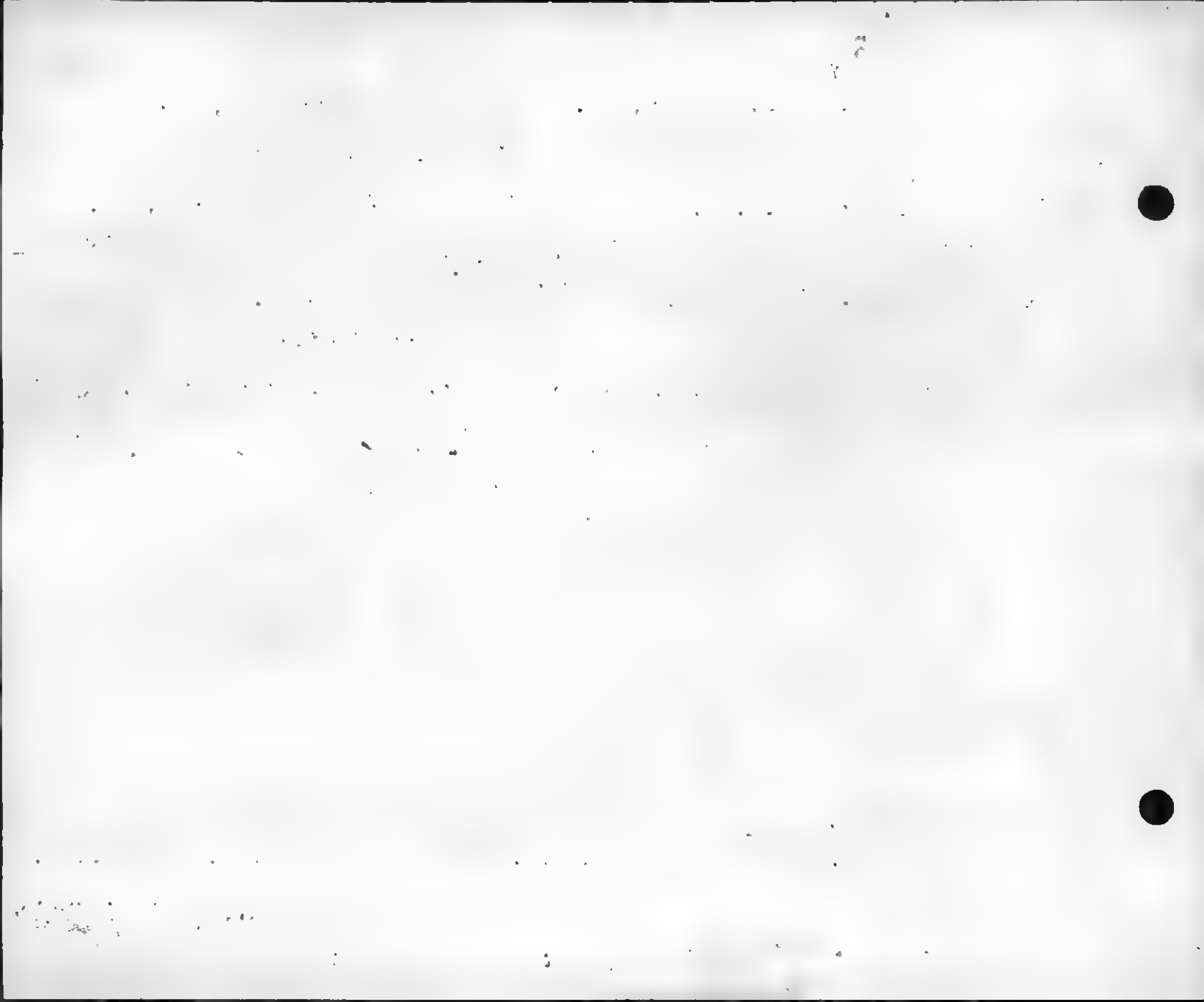
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
30M REV 1/68

MIDDLE
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) James F. Garvey, Jr.			2a. DATE OF DEATH April 12, 1968			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 28, 1892		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.				
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 501 N. Rolling Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Wholesale Plumbing Supplied			12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admssion) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME First Middle Last James Garvey			15. MOTHER'S MAIDEN NAME First Middle Last Mary Higgins							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown none			16b. SOCIAL SECURITY NO 218-32-4735			17. INFORMANT Address Mrs Gertrude I. Garvey 501 N. Rolling Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4/12/68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4+										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec. , 19 60 , to April , 19 68 , that (I) (we) last saw the deceased alive on March 7 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. Sheldon Eastland M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 4/12/68				
22d. PHYSICIAN'S NAME (Type) J. Sheldon Eastland M.D.						22e. ADDRESS Medical Arts Bldg., Balto., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4/16/68			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery-Baltimore, Maryland			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Sterling Funeral Estate 936 Edmondson Ave. Catonsville, Md. 21228						25a. REC'D BY REGISTRAR APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

VR A15 (4)
20M 1/65

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN ID	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chesapeake Manor Nursing Home		e. STREET ADDRESS 525 York Road	
3. NAME OF DECEASED (Type or print) First Middle Last TASSEA S. GEORGE		4. DATE OF DEATH Month Day Year April 20, 1968	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1897
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) Kythera, Greece		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harris Christopher Souris		14. MOTHER'S MAIDEN NAME Beulah Kyprion	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Theodore George Cedar Ave., Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aortic abdominal aneurysm (b) (Diagnosed 1965) (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. YES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary artery disease INTERVAL BETWEEN ONSET AND DEATH. 30 min.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 24, 1958 , to April 20, 1968 , that (I) (we) last saw the deceased alive on April 4, 1968 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George T. Gilmore		22b. DATE SIGNED April 22, 1968	
22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE		22d. ADDRESS 1717 YORK RD, LUTHERVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 23, 1968	
23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery Woodlawn, Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR APR 25 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Margaret Eva Gessler					2a. DATE OF DEATH Month 4 Day 15 Year 68			2b. HOUR 6-0 A M	
3. SEX F		4. RACE W		5. DATE OF BIRTH 12-1-1892		6. AGE (In years lost birthday) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 211 Dunvale Rd. 21204			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER (11)	
14. FATHER'S NAME First Middle Last Augustus Reuwer					15. MOTHER'S MAIDEN NAME First Middle Last Barbra Neuberg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO 212 40 6277		17. INFORMANT Address Elizabeth A. Carpenter, Balto, 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 1963, to April 15, 1968, that (I) (we) lost saw the deceased alive on Jan. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Keith A. Manley MD					22c. DATE SIGNED 4-16-68				
22d. PHYSICIAN'S NAME (Type) KEITH A. MANLEY					22e. ADDRESS 2045, YORK ROAD, TOWSON, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-18-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat.		23d. LOCATION (City or Town) (County) (State) Baltimore, B Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204					25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



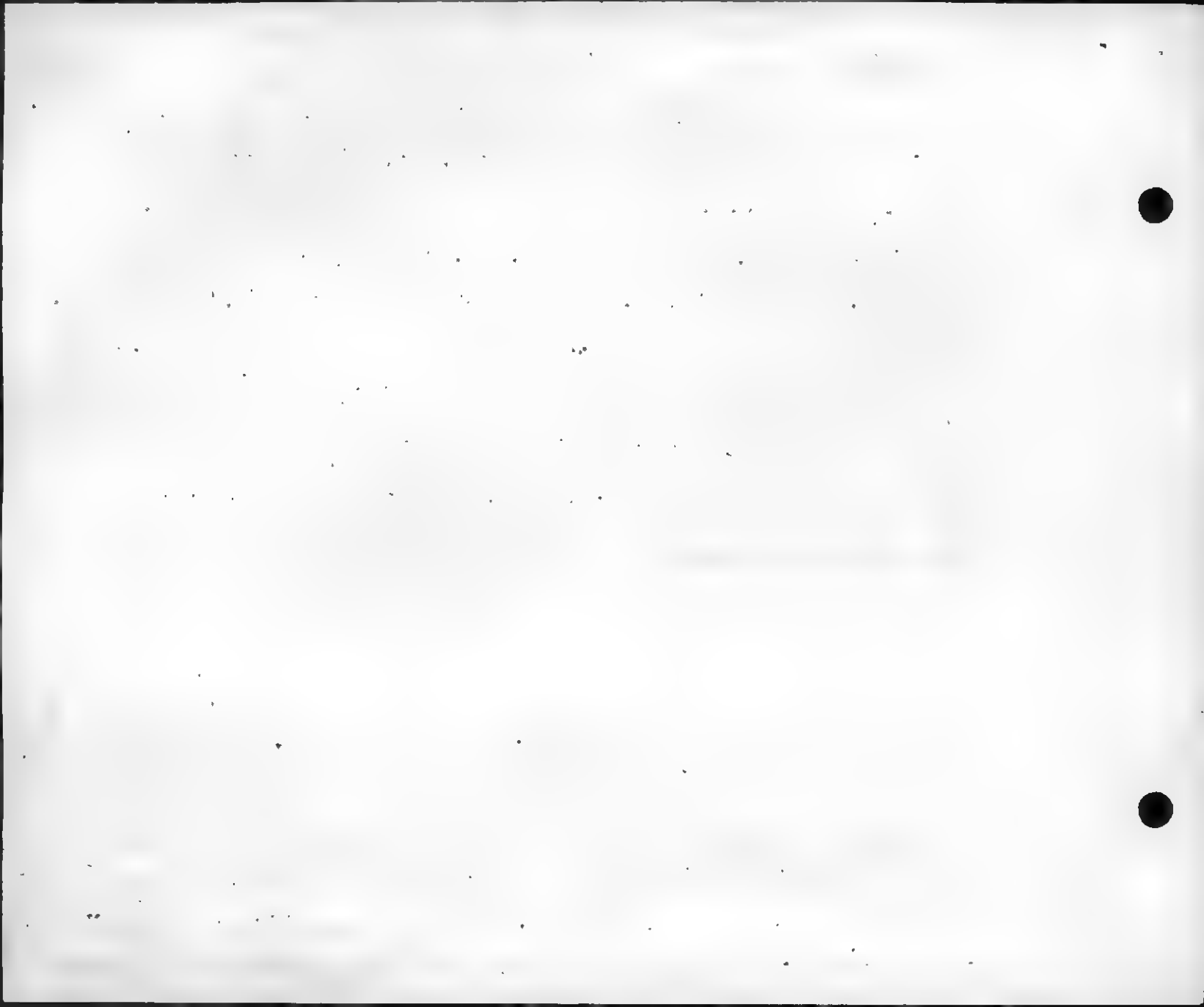
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Morris		First NMI		Middle Goldberg		Last		2a. DATE OF DEATH Month April Day 23 , Year 1968		2b. HOUR 11 MIN 35	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 11, 1900		6. AGE (In years lost birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co.				Md.	
10. CITY OR TOWN OF DEATH Randallstown, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co. Gen.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CLERK		12b. KIND OF BUSINESS OR INDUSTRY FOOD					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 3702 Allenswood Ct.			
14. FATHER'S NAME First Abraham		Middle Goldberg		Last		15. MOTHER'S MAIDEN NAME First ELIZABETH		Middle Goldberg		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 212-22-1326		17. INFORMANT MRS. LILLIAN BERNHARD		Address 3702 ALLENSWOOD CT. #21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4129 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/21 , 19 68 , to 4/23 , 19 68 , that (I) (we) last saw the deceased alive on 4/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Fausto Q. Aquino, Jr. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED 4-24-68			
22d. PHYSICIAN'S NAME (Type) FAUSTO Q. AQUINO, JR.				22e. ADDRESS C/O BALTIMORE COUNTY GEN. HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-25-68		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN ROAD, BALTO. 21215						25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

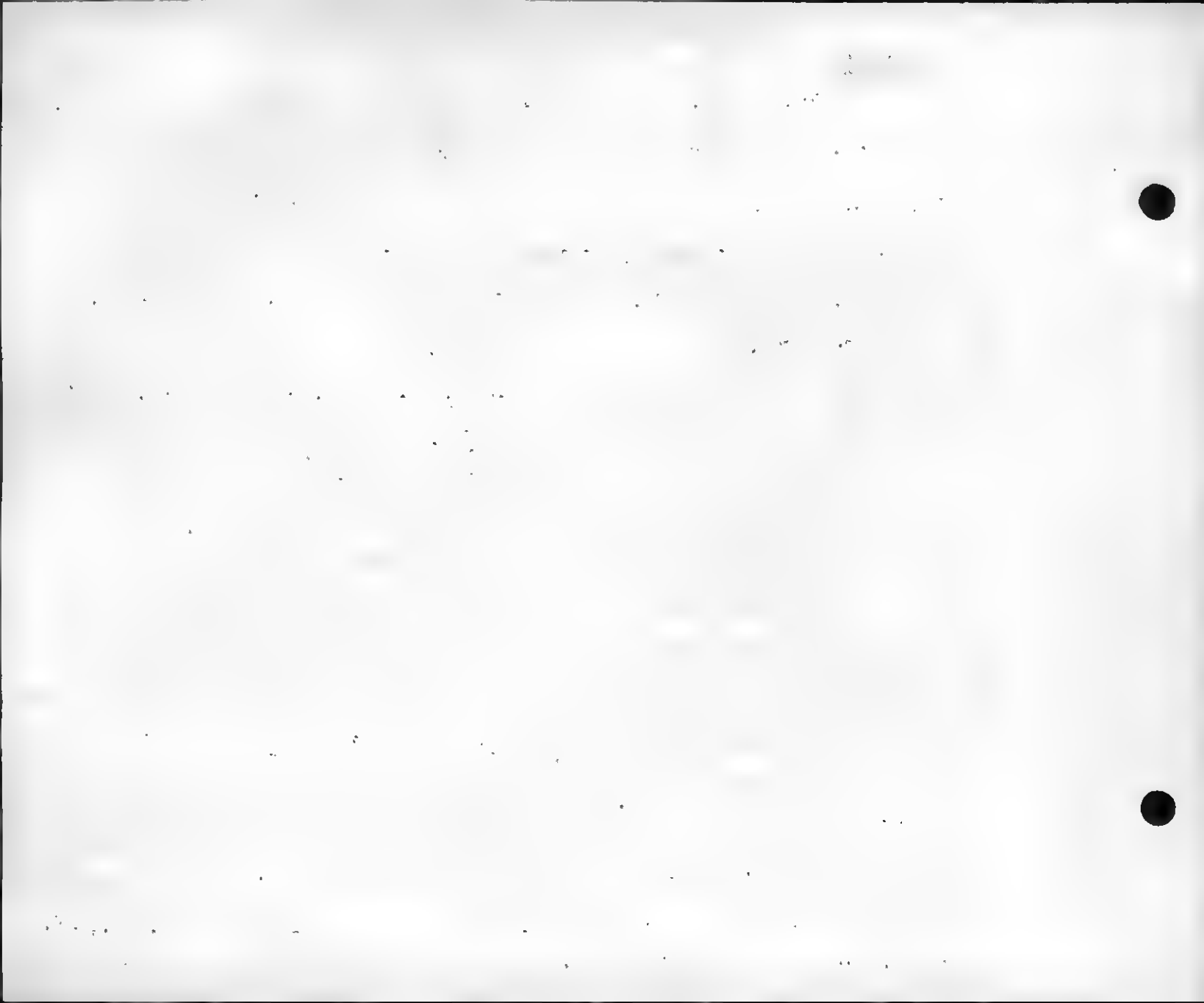
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

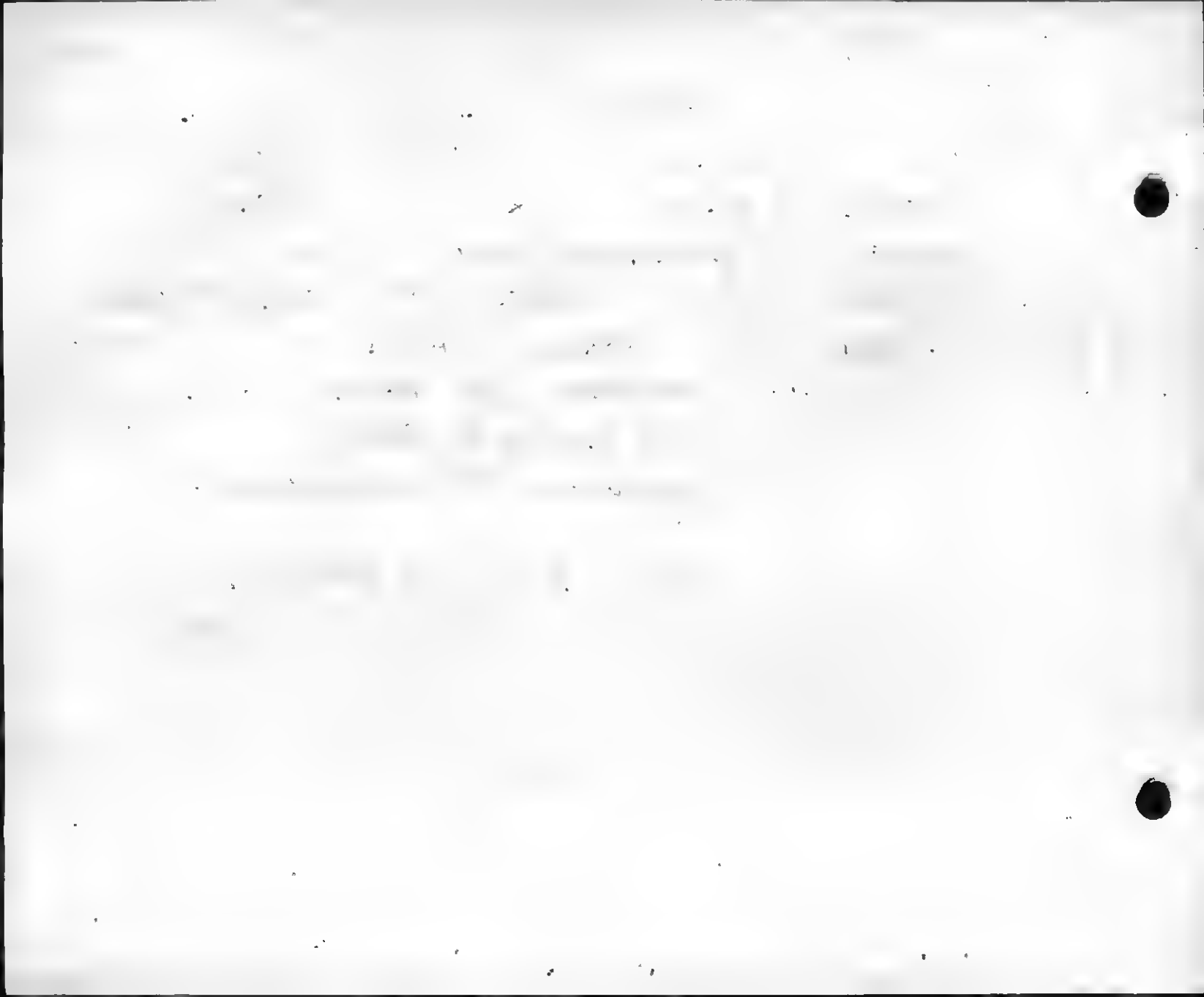
1. DECEASED-NAME (Type or print) IRENE L. GORE		2a. DATE OF DEATH Month APRIL Day 3 Year 68		2b. HOUR 1:30^{am}
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 1-5-06	6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUMMIT NURSING HOME	12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.	13b. COUNTY BALTO.	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9 N. BELLEGROVE RD.
14. FATHER'S NAME First Middle Last WALTER HORTON		15. MOTHER'S MAIDEN NAME First Middle Last LILLIAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE	17. INFORMANT Address LEREOY W. GORE 9 N. BELLEGROVE RD. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the colon with widespread metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> , 19 <u>68</u> , to <u>4/3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE <u>E. Kasaitis M.D.</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/4/68</u>
22d. PHYSICIAN'S NAME (Type) EDMUND KASAITIS		22e. ADDRESS 1801 FREDERICK RD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-6-68	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	23d. LOCATION (City or Town) (County) (State) WOODLAWN, BALTO. CO., MD.	
24. FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229		25a. REC'D BY REGISTRAR DATE APR 10 1968	25b. REGISTRAR'S SIGNATURE <u>Thomas Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		
ALICE		GERTRUDE		GRIBBIN		Month 4 Day 25 Year 68		2b. HOUR 6:22 M		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
F	Can.		2/2/93			76 YRS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
BALTO., MD		U.S.A.				BALTO. Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			GR. BALTO. MED. CENTER			H.W.		OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			—		BALTO		YES		436 E. 28 th Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
NICHOLAS D. LEBRUN			ALICE J. MOONEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT						
YES		220-54-6787		Pt's HISTORY EUGENE N. GRIBBIN Address 2518 CANTLER BURY Rd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>										
(b) <u>Hypertensive cardiovascular disease</u>										
(c) <u>Cirrhosis of liver with jaundice</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.										
21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 14, 1964</u> , to <u>APRIL 25, 1964</u> , that (I) (we) last saw the deceased alive on <u>APRIL 25, 1964</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>T.C. Cullis M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>										
22c. DATE SIGNED <u>APRIL 25-1968</u>										
22d. PHYSICIAN'S NAME (Type) <u>T.C. Cullis MD</u> 22e. ADDRESS <u>Greater Balto. Medical Center</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)										
23b. DATE <u>4/29/68</u>										
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>										
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>										
24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 1905 York Rd. Balto. 12, Md.</u>										
25a. REC'D BY REGISTRAR <u>APR 26 1968</u>										
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

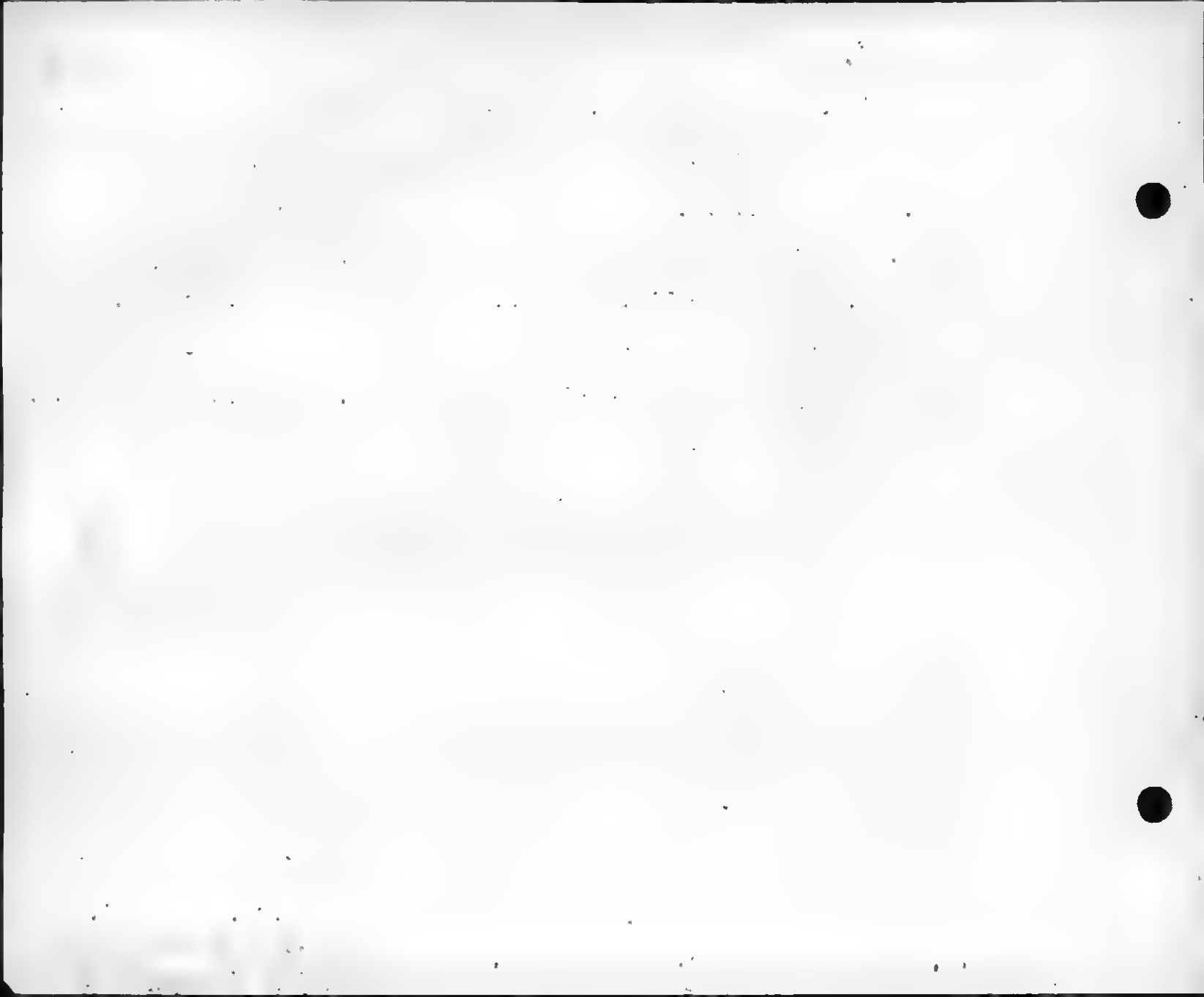
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Bessie Montague Brown Griswold			2a. DATE OF DEATH April Month 19 Day 1968 Year		2b. HOUR 12:30 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH June 11, 1886		6 AGE (in years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Balto. 12	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7 Montrose		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto. 12	3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 7 Montrose Ave.	
14. FATHER'S NAME First Middle Last Alexander Brown		15. MOTHER'S MAIDEN NAME First Middle Last Bessie Montague			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-44-7177		17. INFORMANT Address 11 Alexander B. Griswold Monkton, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized & cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1946 , to April , 1968 , that (I) (we) last saw the deceased alive on April 18 , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Walter B. Buck MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/15/68	
22d. PHYSICIAN'S NAME (Type) WALTER B. BUCK				22e. ADDRESS 18 E. EAGER ST. BALTO 21202	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE 4-22-68		23c. NAME OF CEMETERY OR CREMATORY St. James	
23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.					
24. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto.				25a. REC'D BY REGISTRAR DATE APR 22 1968	
25b. REGISTRAR'S SIGNATURE John A. Judge					

MEDICAL CERTIFICATION



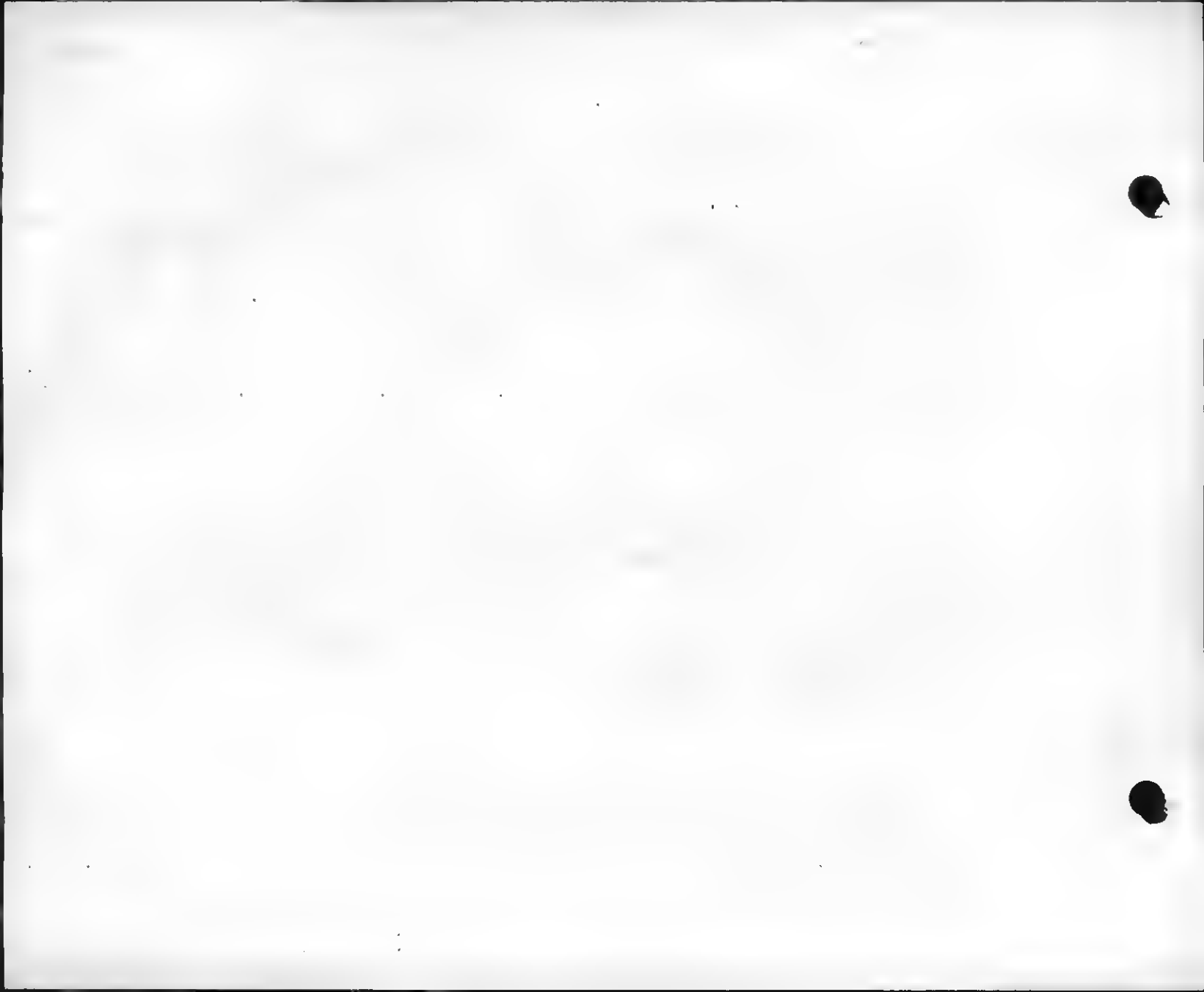
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) MABEL		First XX Middle E. Last GUERKE		2a DATE OF DEATH April Month 26 , Day 1968 Year		2b. HOUR 8:55 PM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH August 21, 1882		6 AGE (in years lost birthday) 85 YRS.	
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First John Middle Callis Last		15 MOTHER'S MA DEN NAME First Mary Middle Pickett Last		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.	
17 INFORMANT Mr. Robert D. Guerke, Jr.		Address 2216 Westchester Ave.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Atherosclerotic Cardio Vascular DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost (b) disease with Gr. IV degeneration DUE TO, OR AS A CONSEQUENCE OF (c) & Coronary Insufficiency & anemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 7-5-68							
19a DATE OF OPERATION		19b CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. F YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 28, 1958 , to Apr. 26, 1968 , that (I) (we) lost saw the deceased o've on Apr. 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Dr. Harry L. Knipp		22c DATE SIGNED 4-27-68		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e ADDRESS 4116 Edmondson Ave., Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4-29-1968		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCAT ON (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229		25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Richard J. Judge	



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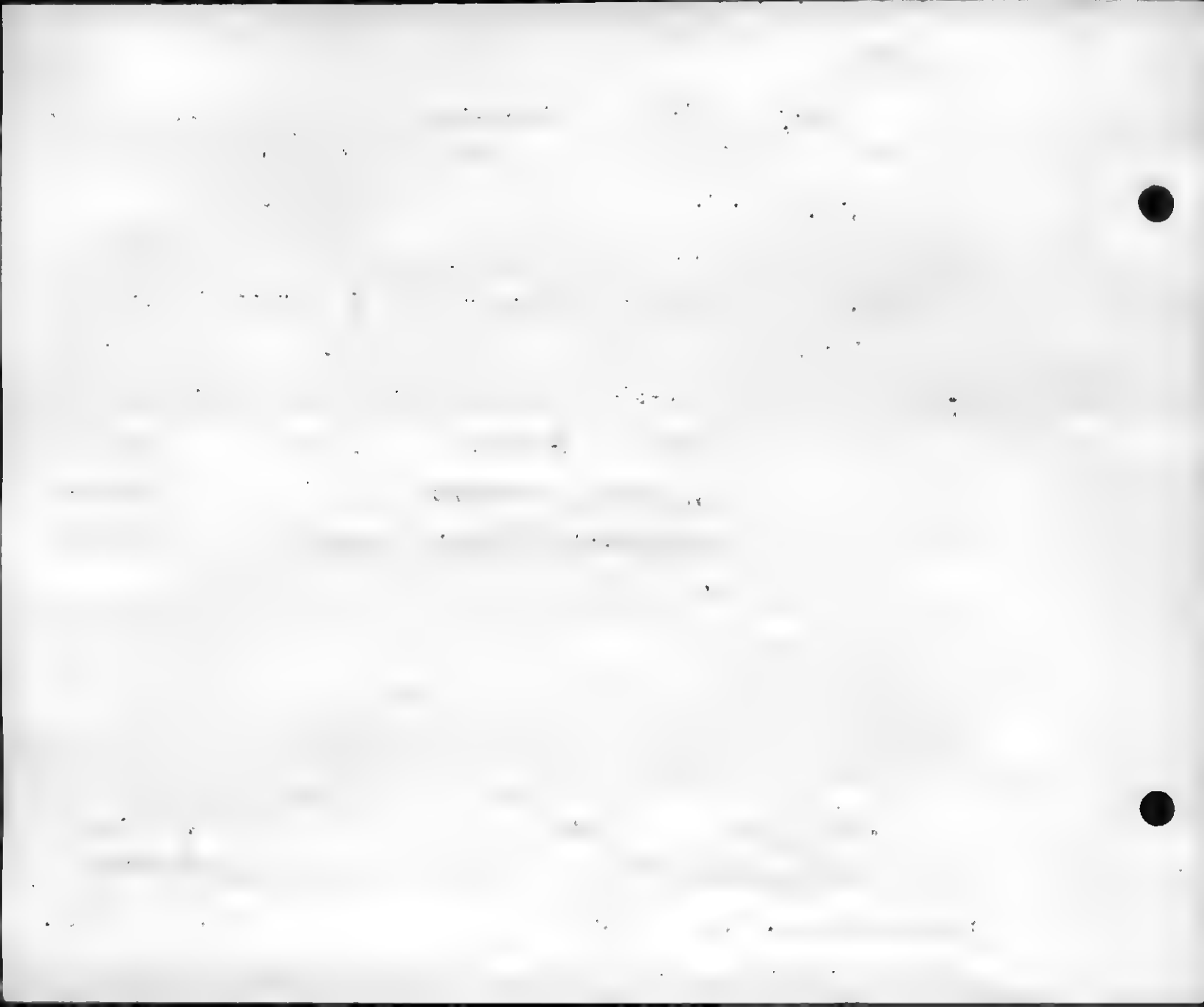
VR A15 (4)
30M REV. 1/68

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55246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last MARY J. HAMILTON			2a. DATE OF DEATH Month Day Year 4 25 68			2b. HOUR 5 A. M.			
3. SEX female		4. RACE white		5. DATE OF BIRTH March 23, 1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Whiteford, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Catonville		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Flintville Road	
4. FATHER'S NAME First Middle Last Harry Hughes			15. MOTHER'S MAIDEN NAME First Middle Last Jane Hughes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 220-54-8935		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN 8 hours YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) OLD AGE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that at (this hospital) attended the deceased from April 17, 1968 , to April 25 19 68 , that (I) was last saw the deceased alive on April 25 19 68 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) diagnose view the body after death.									
22b. SIGNATURE Narciso Aristigueta M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED 4-25-68			
22d. PHYSICIAN'S NAME (Type) NARCISO ARISTIGUETA						22e. ADDRESS SPRING GROVE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Tabernacle		23d. LOCATION (City or Town) (County) (State) Whiteford, Harford, Md.			
24. FUNERAL DIRECTOR John H. Harbins, DELTA, PA.				25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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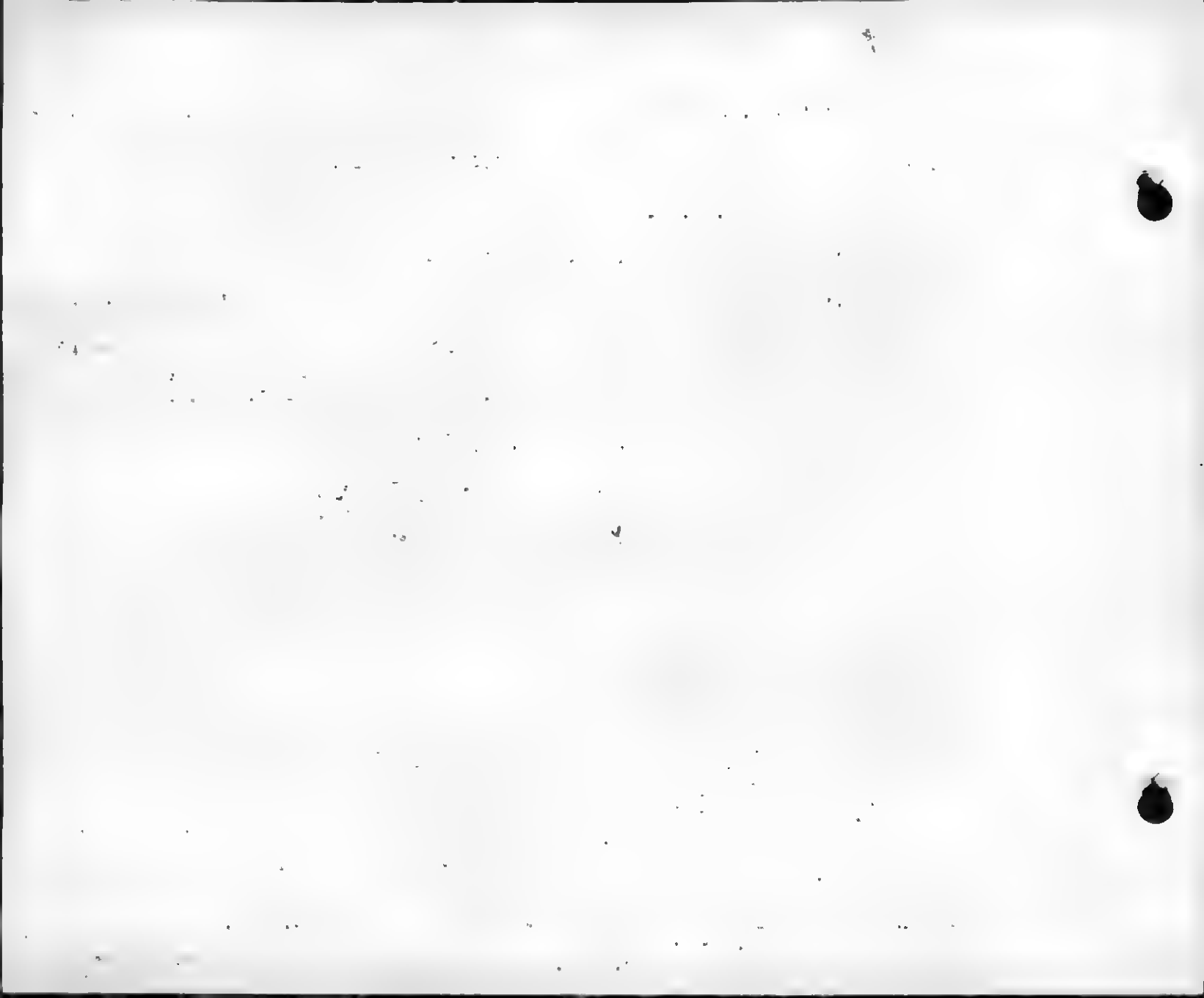
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Estelle M. Harrison			2a. DATE OF DEATH Month APRIL Day 24 Year 68			2b. HOUR 5:00 AM					
3. SEX Female		4. RACE W		5. DATE OF BIRTH 10-16-79		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY 6		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1020 Woodington Rd. (21229)		
14. FATHER'S NAME First Christian Middle Mason Last Mason				15. MOTHER'S MAIDEN NAME First Elizabeth Middle Dowling Last Dowling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT 1020 Woodington Rd. Mrs. May Mantler, Balto., Md. 21229						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vasc. Disease (c) Arteriosclerotic Cardio-Vasc. Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from FEB 10, 1966 , to Apr. 24, 1968 , that (I) (we) last saw the deceased alive on Apr 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harry Knipp						22c. DATE SIGNED 4-24-68					
22d. PHYSICIAN'S NAME (Type) Dr. HARRY Knipp						22e. ADDRESS 4116 Edmondson Ave. 21229					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			23b. DATE 4-26-68			23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			23d. LOCATION (City or Town) (County) (State) Balto., Md.		
24. FUNERAL DIRECTOR 4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229						25a. REC'D BY REGISTRAR DATE APR 25 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge		

MED. CAL. CERTIFICATION

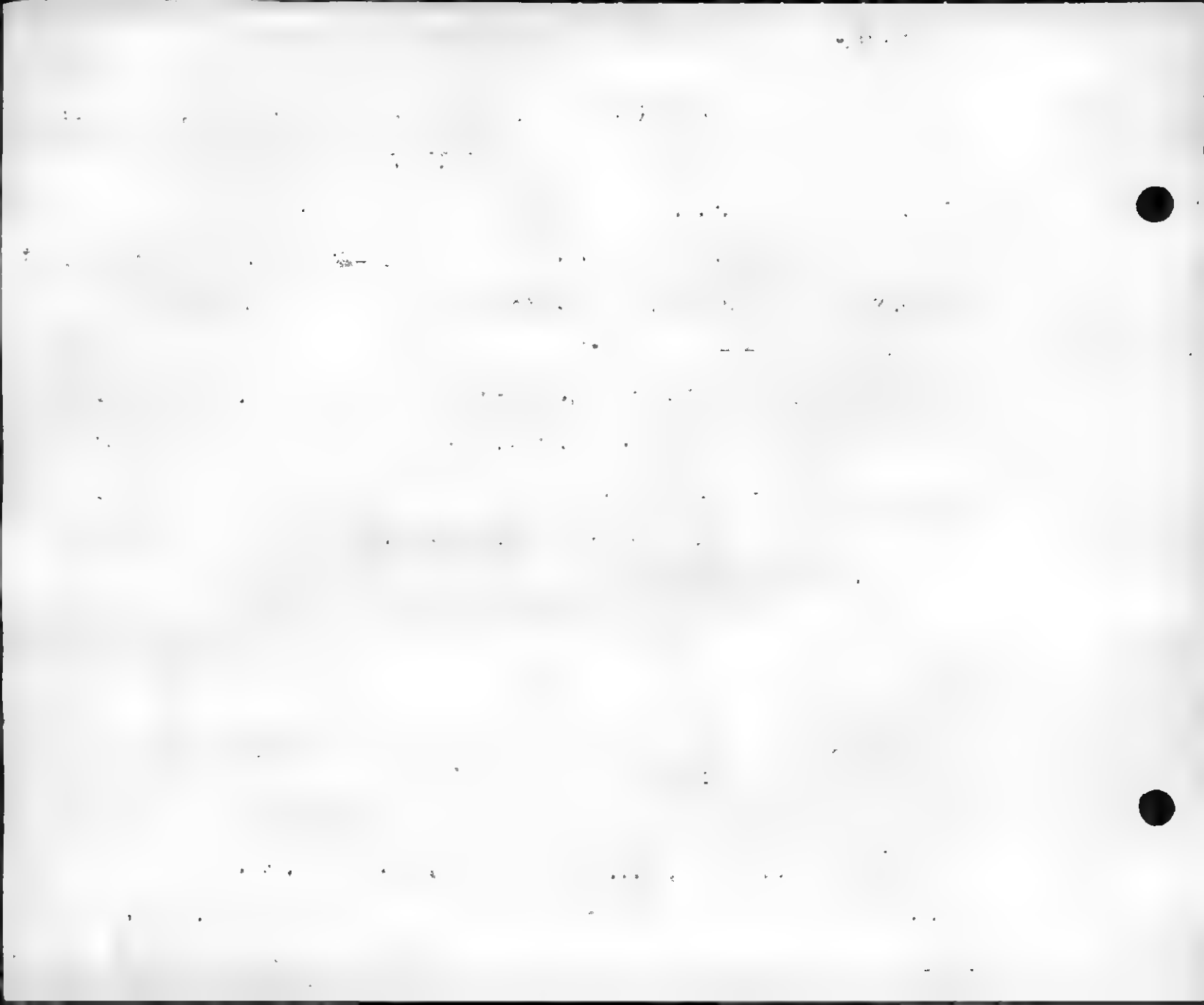


TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
PAUL RADCLIFFE HARTMAN SR.						Month Day Year APRIL 20, 1968		10:50PM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		11/27/97		70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND		U.S.A.				BALTIMORE		CONSTRUCTION	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
FORT HOWARD			VETERANS ADMIN. HOSPITAL			SELF-EMPLOYED			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. RIDE CITY LIM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		Dundalk				3506 LOUTH ROAD	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
ISAAC - - HARTMAN			Volear Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
YES		WWII		212 20 06 76		CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA								DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMEALY								YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE								YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
74 PATCHY BRONCHOPNEUMONIA.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (a) (this hospital) attended the deceased from APRIL 17, 19 68, to APRIL 20, 19 68, that (a) (we) last saw the deceased alive on APRIL 20, 19 68, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (not) view the body after death.									
22b. SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
MARIO S. QUIROS, M.D.						VAH, FT. HOWARD, MD.			
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4/24/68		BALTIMORE NATIONAL		BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DUDAS FUNERAL HOME, 7922 WISE AVE BALTO MD				DATE APR 24 1968		Charles Judge			



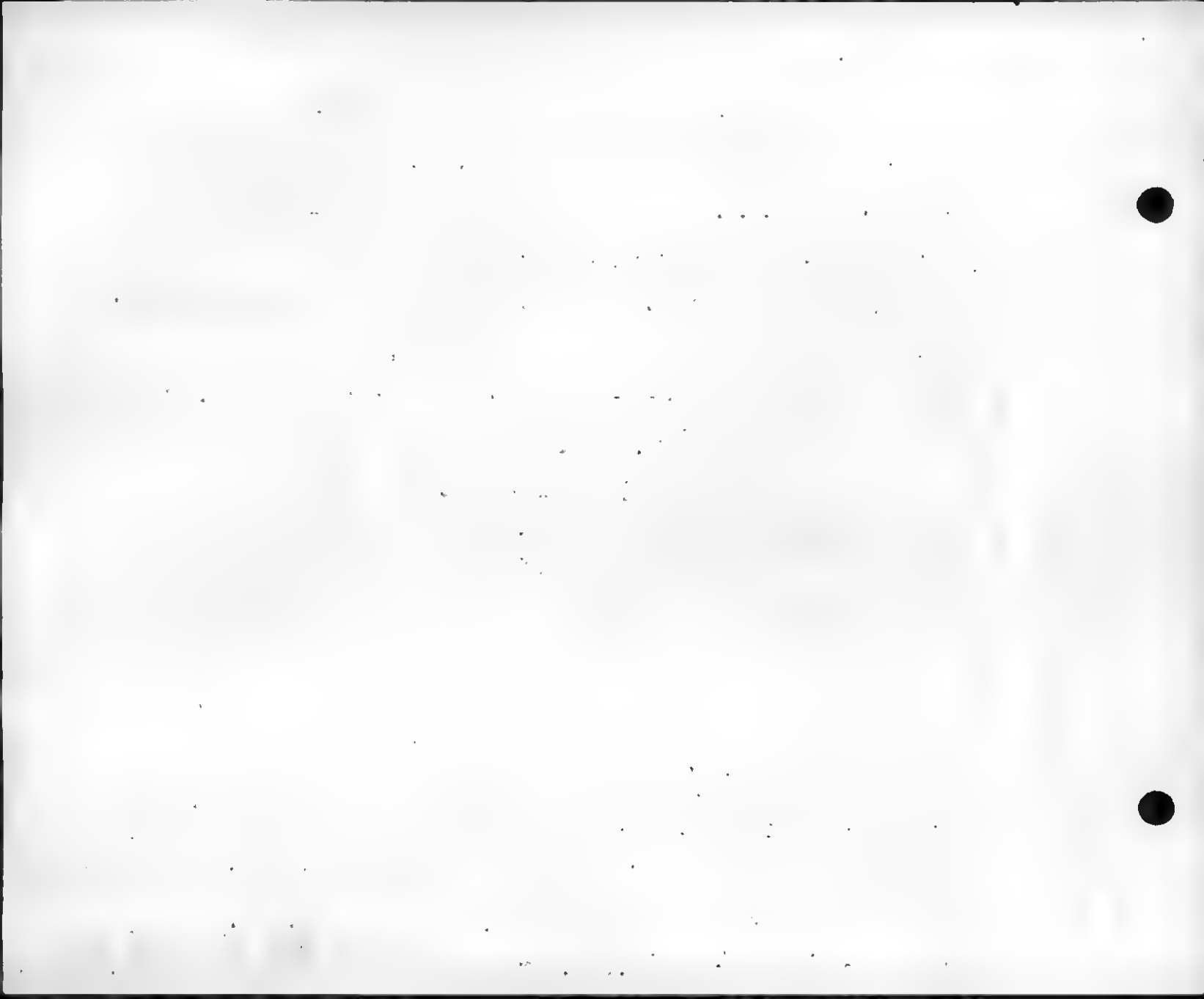
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (4)
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Pauline Hartung		2a. DATE OF DEATH Month April Day 14 Year 1968		2b. HOUR M	
3 SEX Female	4 RACE W	5 DATE OF BIRTH Sept. 17, 1886		6 AGE (in years last birthday) 81 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Baltimore		10. CITY OR TOWN OF DEATH BALTO. CO. MD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summitt Nursing Home	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b COUNTY Balto.		13c CITY OR TOWN Baltimore	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3624 Edmondson Avenue			
14 FATHER'S NAME First Henry Hartung Middle Last		15. MOTHER'S MAIDEN NAME First Pauline Hagan Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-10-5329		17. INFORMANT 702 Braeside Road Dorothy Ashburn, Balto., Md. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS 1571 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA - PANCREAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 18 mo -					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 1571					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1968 , to APRIL 14 1968 , that (I) (we) lost saw the deceased alive on APRIL 13 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Norman R. Kleinman DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/15/68			
22d. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN		22e. ADDRESS 3803 EDMONDSON AVE -			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4-18-68		23c NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
23d LOCATION (City or Town) Balto., Md. (County) (State)					
24. FUNERAL DIRECTOR Wit zke Funeral Directors, Balto., Md. 21229		25a. REC'D BY REGISTRATION DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

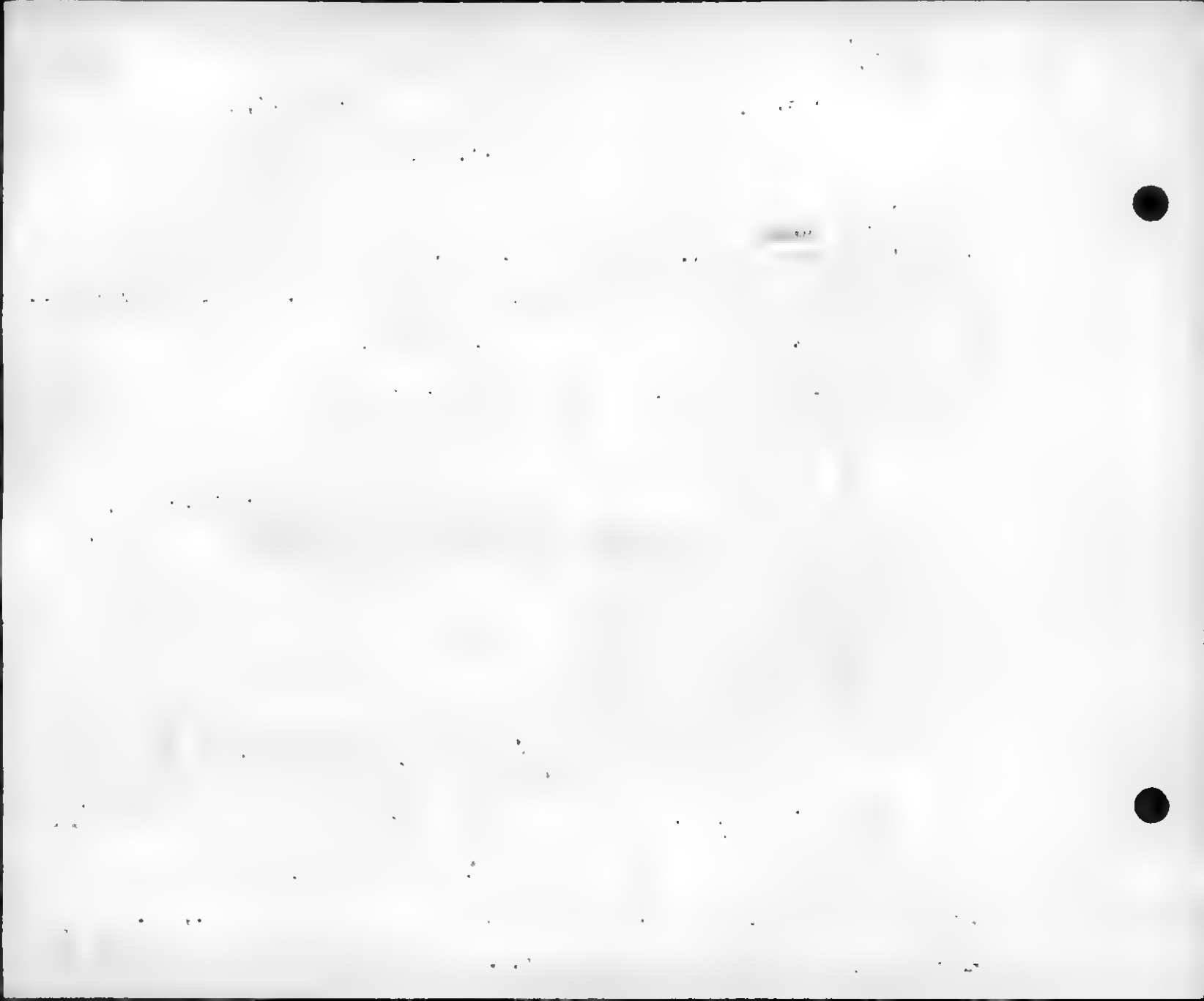


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MEDICAL CERTIFICATION

<div style="text-align: center;"> <div>35250</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div>									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
SAMUEL P. HAUCK						April 22, 1968			2 AM M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Male		White		Oct. 16, 1900		87 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10 IF UNDER 24 HRS	
Maryland		USA				Baltimore		Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Rural Bowley's Quarters			Rt. 15 Seneca Gardens Rd.			Chauffeur			Truck
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Baltimore		Rural	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 15 Seneca Gardens Rd.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last William Hauck			First Middle Last Lizetta Lochmiller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> W.N.I.			218 10 5529A		Hilda Hauck		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
410.9 Coronary Thrombosis arteriosclerotic Coronary Disease Auricular Fibrillation									15 minutes 5 yrs 5 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		City or Town		County State	
				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from JAN 10, 1963, to April 22, 1968, that (I) (we) lost saw the deceased alive on April 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Joseph Pokorny MD								4/23/68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DR JOSEPH POKORNY					2200 E Madison St				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		4/25/68		Oak Lawn Cemetery		Baltimore Co., Md.			
24. FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Bruzdzinski Funeral Home 1407 Eastern Ave.					DATE APR 24 1968		John J. J...		



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VR A15 (4)
30A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b. HOUR		
Marie Ruppertsberger Hawkins						Month Day Year April 29, 1968		2:45 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (n years last birthday)		IF UNDER 1 YEAR		
female		white		May 6, 1903		64 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
Md.		U. S. A.				Baltimore		Md.		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			housewife		Own Home		
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			Pr. Geo. ✓		Larchmont		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 Park Drive	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
George Gustave Ruppertsberger				Mary Elizabeth Doberer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b SOCIAL SECURITY NO.		17. INFORMANT Address				
no				none		Records: SPRING GROVE STAT. HOSPITAL				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death,									sudden (min)	
410.7 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Heart Dis									15 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, senile.									15 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
a) Obesity (270lbs.), exogenous; b) Diabetes Mellitus, age onset, mild.										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from April 29 1968, to April 29 1968, that (I) (we) last saw the deceased alive on April 29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b SIGNATURE						22c. DATE SIGNED				
Anthony J. Young, M.D.						4-29-68				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Anthony J. Young, M.D.						SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		May 1, 1968		Loudon Park Cemetery		Baltimore M.d. Balto. Md.				
24. FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Hyattsville, Md.						MAY 3 1968		Charles Judge		

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

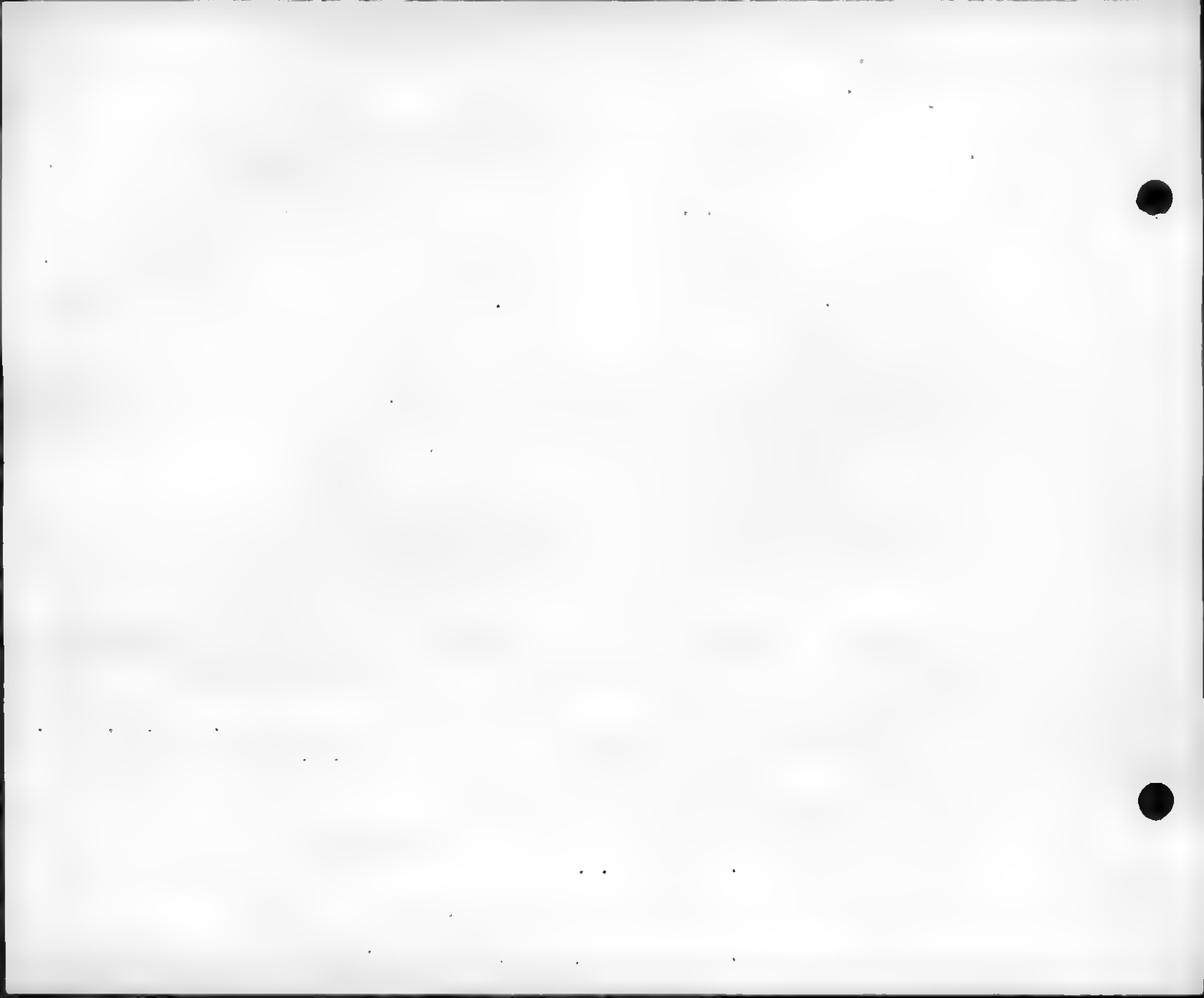
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05252

05256

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
DOROTHY			HENRY			X			4 23 1968			6:35			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD			Month Day Year			2d. HOUR			
Female	White	6-20-1216	51 YRS			April			23 19			686:35			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Indiana			U.S.A.						Balto.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Balto.			9525 Pulaski Highway			Housewife			Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input type="checkbox"/>			9525 Pulaski Highway			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last						
Edwin			Little			Bernice			Richardson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			383-076331			Mr Oakley E. Henry			2525 Pulaski Highway			21237			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Barbiturate ingestion</u>															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
(b) <u></u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u></u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. P.M. 4 23 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			Ingested barbiturates						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION: Street or R.F.D. No			City or Town			County State			
			Home?			9525 Pulaski Highway			Balto.			BALTO. Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			Edward F. Wilson, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			April 24, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			4-27-1968			Grandville, Cemetery			Grandville,			Michigan			
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home 7402 Belair Road						BALTO.						DATE APR 29 1968		Charles Judge	



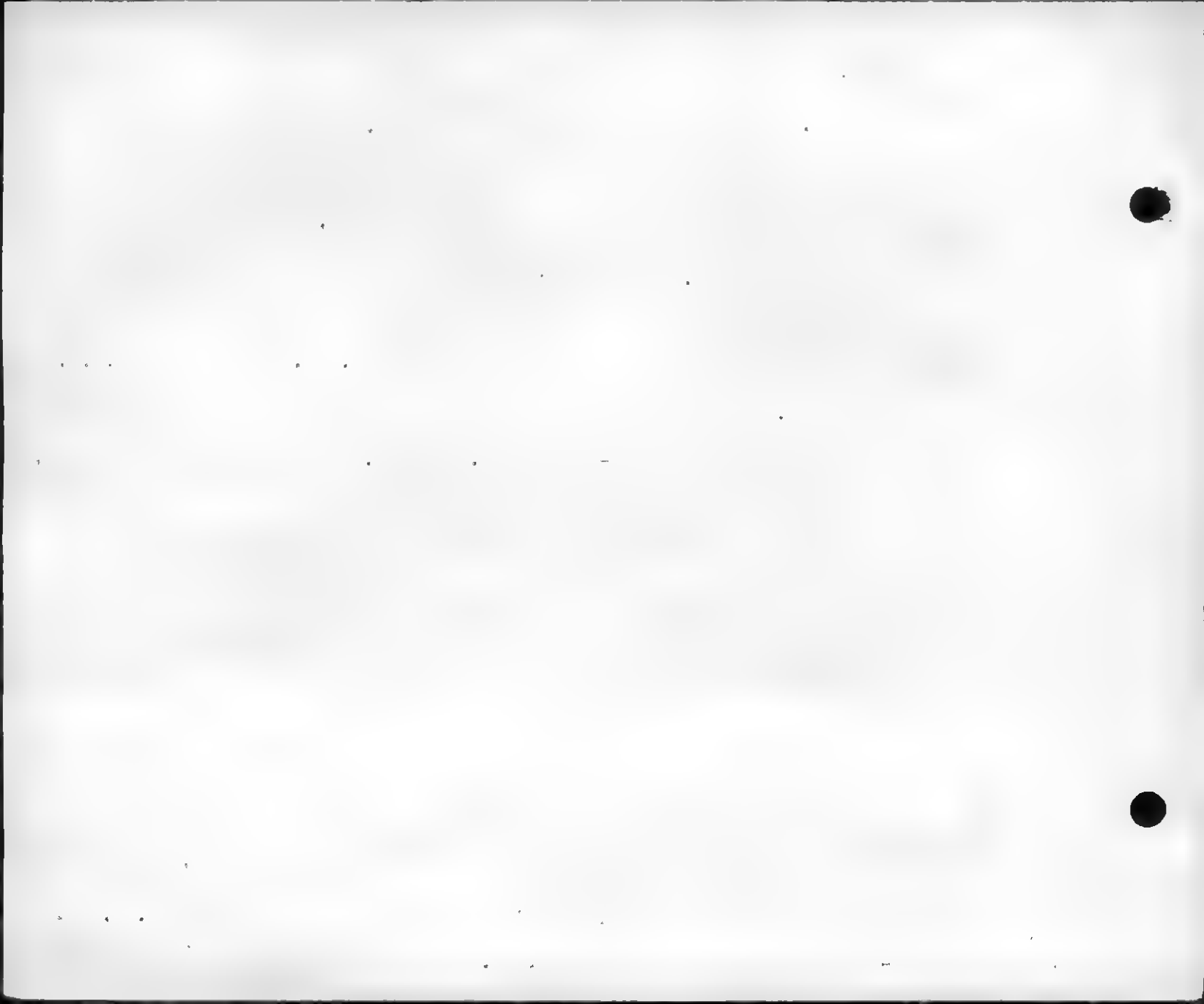
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

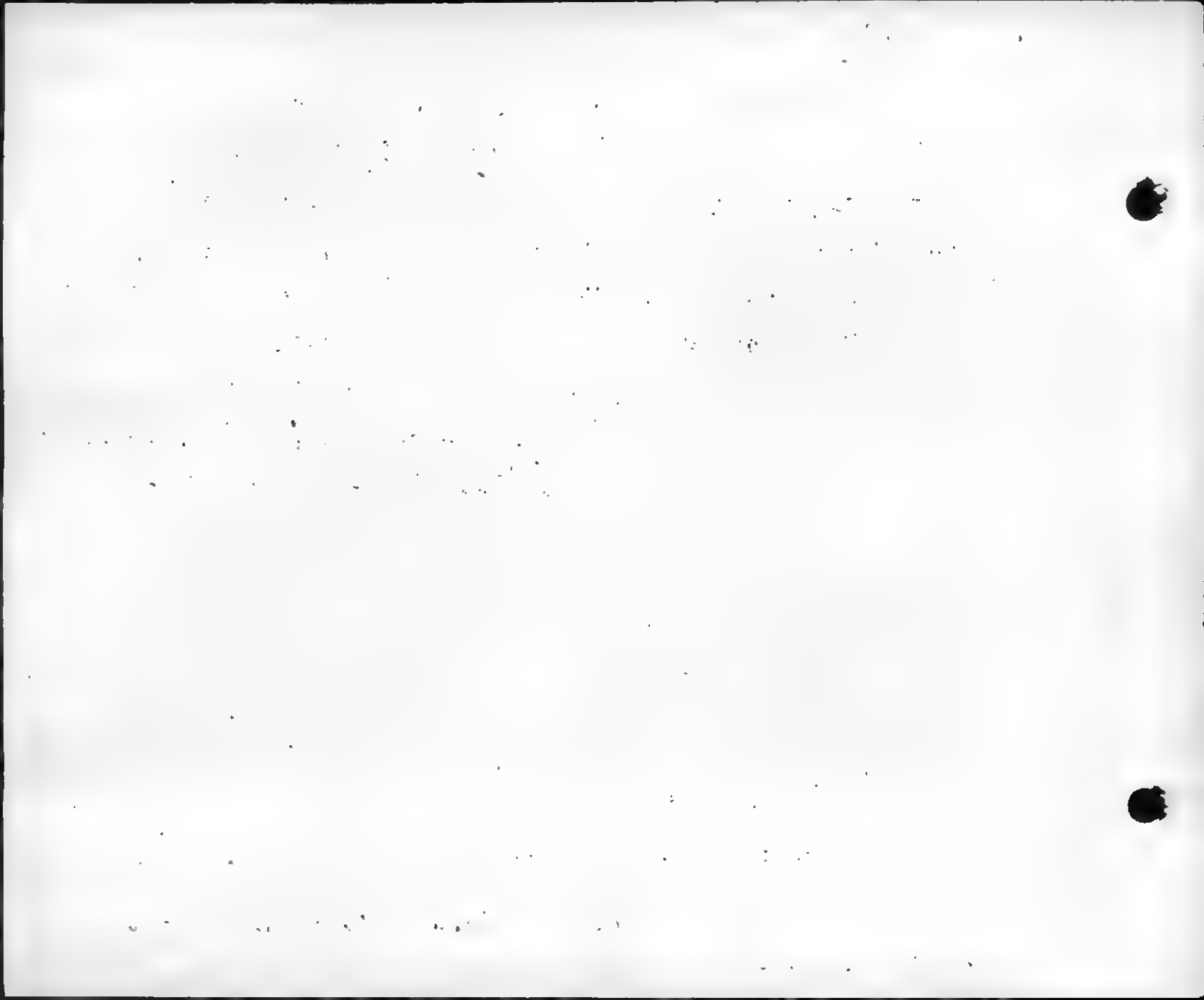
1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CHAPELL HILL NURSING HOME		e. STREET ADDRESS Park Ave.	
3. NAME OF DECEASED (Type or print) First Cora Middle E. Last Hoffacker		4. DATE OF DEATH Month 4 Day - 10 Year 1968	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1886
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah F. Hoffacker		14. MOTHER'S MAIDEN NAME Jonna Hare	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) NO		16. SOCIAL SECURITY NO. 219-30-7068A	
17. INFORMANT Mrs. Harry W. Armacost		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Bronchopneumonia X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Aspiration due to inability to swallow. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ③ Chronic Brain Syndrome and Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6 - 11 - 1967 , to 4-10 - 1968 , that (I) (we) last saw the deceased alive on 4-10-1968 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Caverio		22b. DATE SIGNED 4-10-68	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22d. ADDRESS 8629 Liberty Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 13, 1968	23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	23d. LOCATION (City or Town) (County) (State) Hampstead Baltol Co. Md.
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home		25. REC'D BY REGISTRAR APR 15 1968	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) NORMAN L. HOFFHEISER					2a DATE OF DEATH APRIL 21 1968		2b HOUR 6:54 AM		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH APRIL 21, 1901		6 AGE (n years lost, birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) STILTZ, MD.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH TOWSON BALTIMORE 4, MD.			
10 CITY OR TOWN OF DEATH TOWSON, MD.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) G & E LINE MAN		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE BALTIMORE 12, MD.		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1335 GITTINGS AVE. #12			
14 FATHER'S NAME First Middle Last ALBERT HOFFHEISER				15 MOTHER'S M A D E N NAME First Middle Last ANNIE BAICER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 212-05-6005		17 INFORMANT Address MRS. HOFFHEISER					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Acute									
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease									
DUE TO, OR AS A CONSEQUENCE OF (c) 4 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 4/1 , 19 68 , to 4/21 , 19 68 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Ruben Sebastian, M.D.		22c DATE SIGNED 4/21/68		22d PHYSICIAN'S NAME (Type) RUBEN S. SEBASTIAN, M.D.		22e ADDRESS 2314 E. JOHNS RD., BALTO. #34			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-24-68		23c. NAME OF CEMETERY OR CREMATORY Bohemian National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR John C. Miller Inc-415 Belair Rd.-21206				25a REC'D BY REGISTRAR DATE APR 24 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



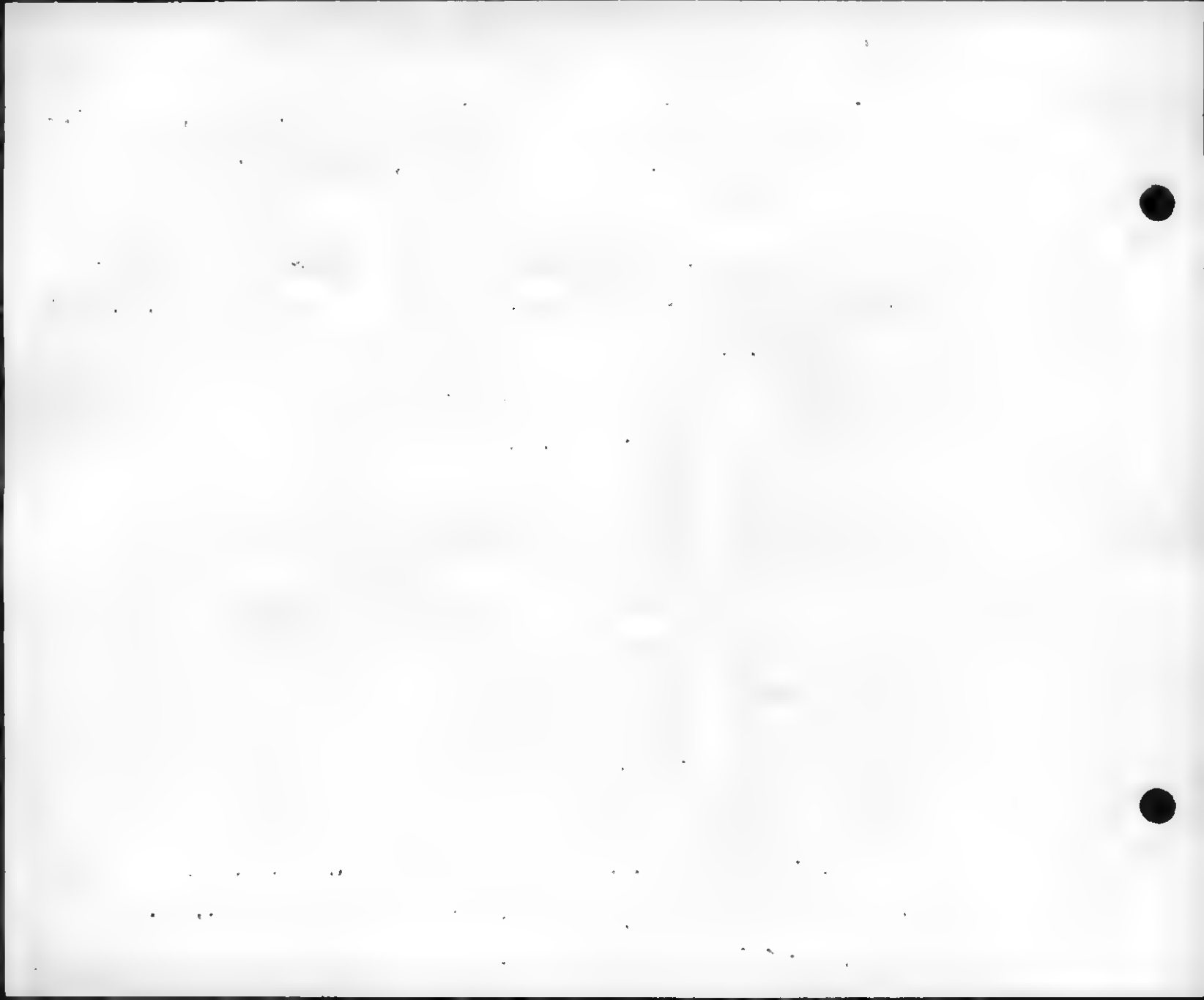
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VR A 15 (4)
30M REV 1/68

MD 255
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last EDWARD DORSEY HOFFMAN			2a DATE OF DEATH Month Day Year April 26, 1968		2b HOUR 3:50AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH March 3, 1894		6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTRY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Towson	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Butcher	12b KIND OF BUSINESS OR INDUSTRY Meat Packing	
13a USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN Essex	13d INSIDE CITY LIM 15- YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	14 STREET AND NUMBER 468 Barrison Pt. Rd. 21221	
14 FATHER'S NAME First Middle Last Edward D. Hoffman			15 MOTHER'S MAIDEN NAME First Middle Last Anna Miller		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WWI	16b SOCIAL SECURITY NO 213 03 9210	17 INFORMANT Address Anna Hoffman Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4104 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State
22a I certify that (I) (this hospital) attended the deceased from April 18, 1968 , to April 26 19 68 , that (I) (we) last saw the deceased alive on April 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>E. Montelibano</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c DATE SIGNED April 26, 1968
22d PHYSICIAN'S NAME (Type) E. Montelibano, M.D.		22e ADDRESS 7620 York Rd. Towson, Maryland 21204			
23a BURIAL, CREMATION, or other disposition Burial	23b DATE 4/29/68	23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore Co., Md.		
24 FUNERAL DIRECTOR Brazdzinski Funeral Home 1407 Eastern Ave.			25a REC'D BY REGISTRAR DATE APR 29 1968	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

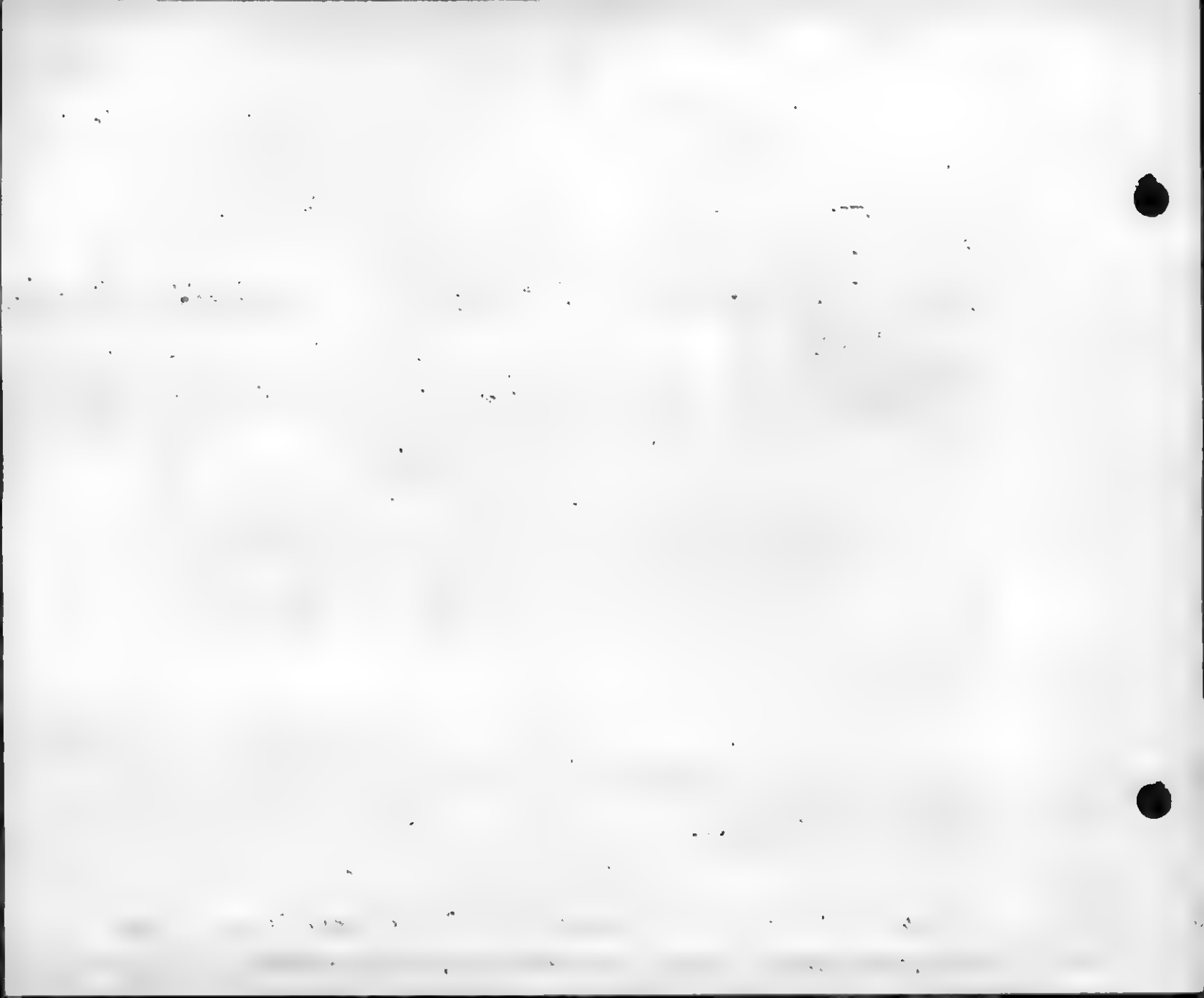


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Virginia A. Hoffman						2a. DATE OF DEATH Month Apr. Day 23 Year 1968			2b. HOUR 1 A. M.		
3 SEX FEMALE		4. RACE White		5. DATE OF BIRTH 8-26-02		6. AGE (In years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.		
10. CITY OR TOWN OF DEATH LINCOLN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 334 WINDY AVE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AT-HOME			12b. KIND OF BUSINESS OR INDUSTRY 		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence, before admission) STATE MARYLAND			13b. COUNTY Baltimore			13c. CITY OR TOWN OVERLEA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 334 WINDY AVE RD.	
14. FATHER'S NAME First HENRY Middle F. Last BUCKHART				15. MOTHER'S MAIDEN NAME First FRANCES Middle CAROLINE Last TIGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 212-10-6039A		17. INFORMANT VERNON K. HOFFMAN SR Address 703 OLD HOME RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 11-27 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1965 to Apr. 23, 1968 , that (I) (we) last saw the deceased alive on April 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Donald Jandorf DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 4-23-68			
22d. PHYSICIAN'S NAME (Type) Donald Jandorf								22e. ADDRESS 6077 Harford Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE APR 26, 68		23c. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH		23d. LOCATION (City or Town) BALTO. CO. MD		(County)		(State)	
24. FUNERAL DIRECTOR DIPPEL BRO'S INC				ADDRESS 7110 BELAIR RD		25a. REC'D BY REGISTRAR APR 24 1968		25b. REGISTRAR'S SIGNATURE Francis Jones			

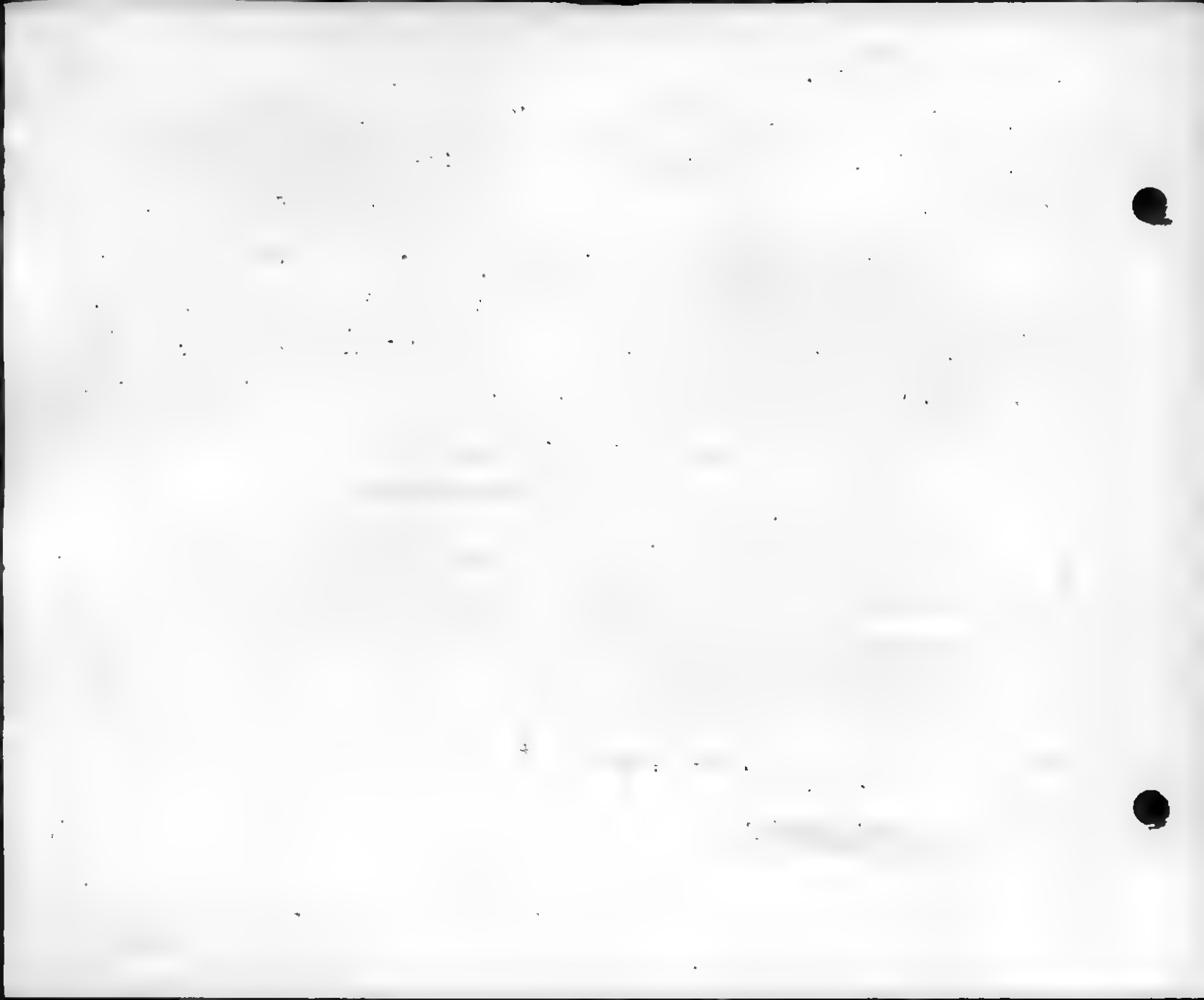


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers 1, 2 and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 257
MAY 25 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) ALMA REGINA HUBBARD			2a DATE OF DEATH Month APRIL Day 20 Year 1968			2b. HOUR 2:45 PM	
3 SEX FEMALE		4 RACE Caucasian		5. DATE OF BIRTH 4-29-86		6 AGE (In years last birthday) 81 YRS.	
7a BIRTHPLACE (State or foreign country) BALTO. MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md.	
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) G.B.M.C.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY XXXX.	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b COUNTY BALTIMORE		13c. CITY OR TOWN Lutherville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Gustave DOLPHUS KIMMETT		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Stauffer		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) UNKNOWN			
16b SOCIAL SECURITY NO Not known		17 INFORMANT Address Mrs. Alma R. Haddaway, 845 Kellogg Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-20-1968 , to 4-20-1968 , that (I) (we) lost saw the deceased alive on 2:45 pm 4-20-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. Haddaway		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-20-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-23-1968		23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS		25a. REC'D BY REGISTRAR APR 23 1968		25b. REGISTRAR'S SIGNATURE J. H. Jones	



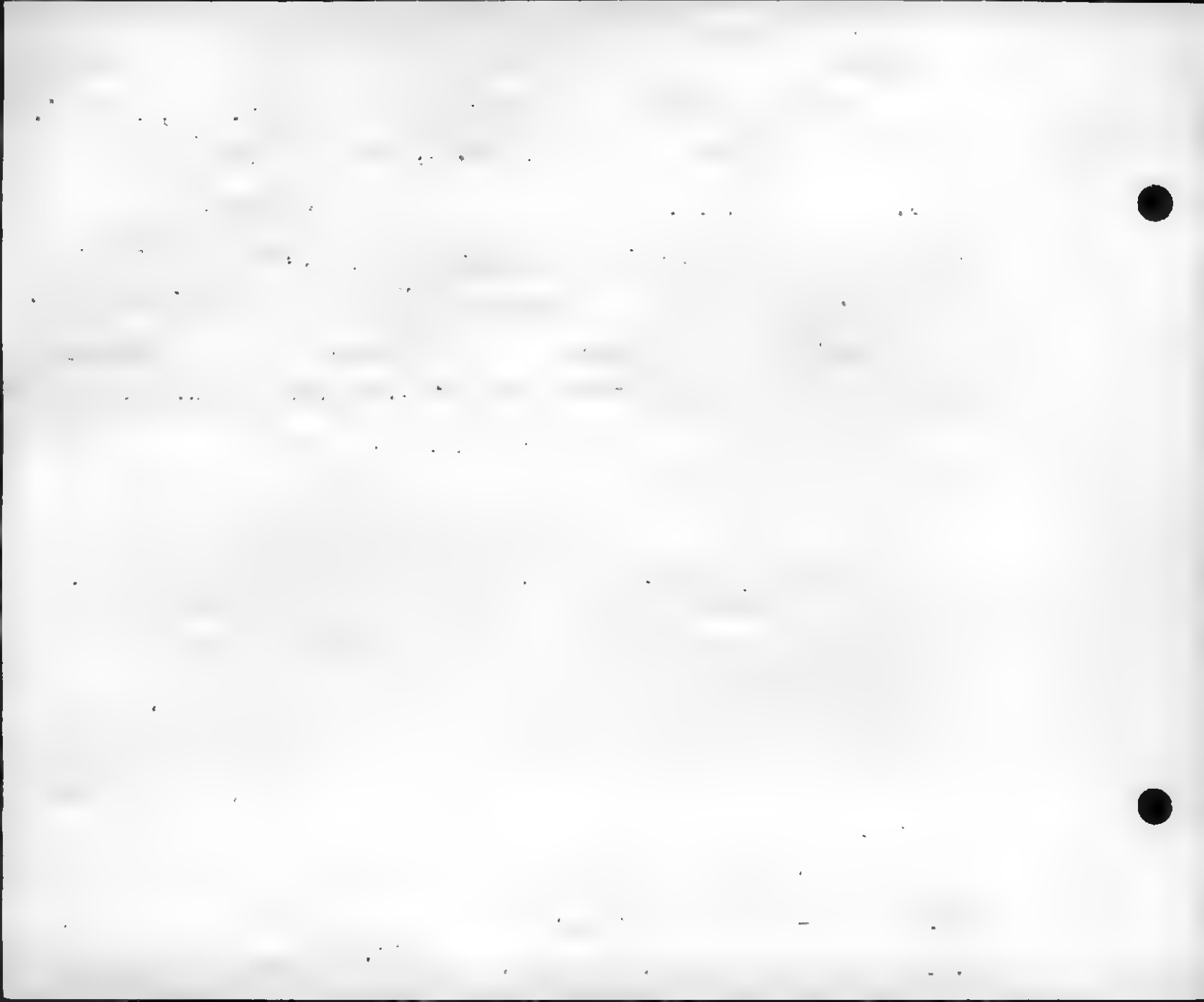
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Edna Livina Hulsey			2a. DATE OF DEATH Month Apr. Day 16 Year 1968			2b. HOUR 8:35 AM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH Mar. 20, 1882		6. AGE (In years last birthday) 86 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md							
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caton Ridge Nursing H			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) R. Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Park Heights Ave.	
14. FATHER'S NAME First Frank Middle Ausburn Last Swanger				15. MOTHER'S MAIDEN NAME First Mary Middle Swanger Last Swanger									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 214-20-6462				17. INFORMANT Margaret H. Weisensel				Address 41 N. Prospect Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4912 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arteriosclerosis - urethral stricture													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 1-4-1966 , to 4-16-1968 , that (I) (we) last saw the deceased alive on 4-16-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Cesar Valle Cervero						DEGREE MED. DIRECTOR		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-17-68			
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO						22e. ADDRESS 8629 Liberty Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-17-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) Baltimore		County Md.		State			
24. FUNERAL DIRECTOR G. Howard Strong						ADDRESS 3207 W. North Ave.		25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE William J. Judge			

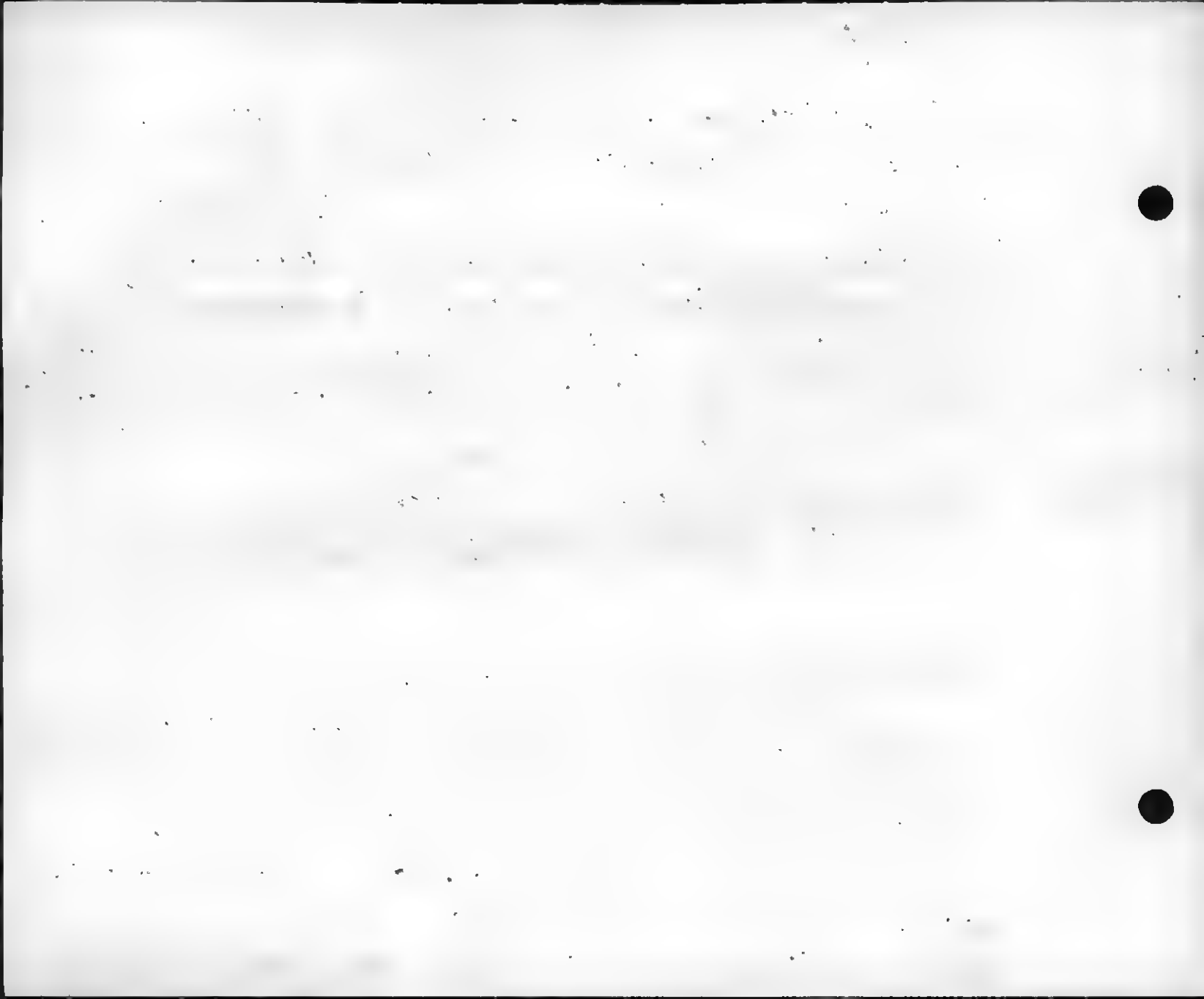


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23a

05263

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
ANGELINE WHITE HUNTER										4		3		1968		3:30 P.M.	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		IF UNDER 24 HRS HOURS		IF UNDER 24 HRS MIN.	
FEMALE		CAUCASIAN		3/28/1888		80 YRS.		BALTIMORE									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
PENNA		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE											
1d. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
CATONSVILLE		HOUSE IN PINES		HOUSE WIFE													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER									
MD		BALTO.		DUNDALK				16 TOWNSHIP RD									
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last															
UNK.		UNK.															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT - ATTORNEY - Address													
NO		217-48-8466		WM. H. ROUECAMP - 5 CENTER MD. 21228													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia T.O.I. DUE TO, OR AS A CONSEQUENCE OF (b) Fracture Left Humerus DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 da. 13 da. 5 yr.		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) H																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)													
<input checked="" type="checkbox"/> DR. CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		7 P.M. 3 21 1968		Unknown.													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC.) Living Home		21f. LOCATION Street or R.F.D. No. City or Town County State													
				16 Easting Ave. Catonsville Baltimore Md.													
22a. I certify that (I) (this hospital) attended the deceased from 2-5-, 1968, to 4-3-, 1968, that (I) (we) last saw the deceased alive on 4-1- 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED									
Wilmer K. Gallagher M.D.								4/3/68									
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS															
Wilmer K. Gallagher M.D.		6209 Frederick Ave. Baltimore, Md. 21228															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)											
BURIAL		4/5/68		OAK LAWN		BALTO. CO. MD											
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE											
W. Ruth Dudley, Leinbach, Md.				DATE - APR 5 - 1968		Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

1
M
35260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Hilda ----- HURLEY			2a. DATE OF DEATH Month Day Year April 27 1968			2b. HOUR 2:15 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH October 15, 1907		6 AGE (In years last birthday) 60 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10 CITY OR TOWN OF DEATH Catonsville-21228.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE 1517 W. Lombard Str Baltimore City		13b. COUNTY 1517 W. Lombard Str Baltimore City		13c CITY OR TOWN 1517 W. Lombard Str Baltimore City		13d INSIDE CITY LIM IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1517 W. Lombard Street	
14 FATHER'S NAME First Middle Last ? deceased			15 MOTHER'S MAIDEN NAME First Middle Last ? deceased			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no			
16b SOCIAL SECURITY NO none			17 INFORMANT Address Mrs. Lillian Wells 4016 Brendon Ave. 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Uremia, Hypertension, Chronic Alcoholism.									
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year none		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1967 , to April 27, 1968 , that (I) (we) last saw the deceased alive on April 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr Imre Kopits						22c. DATE SIGNED April 27, 1968		22d. PHYSICIAN'S NAME (Type) Dr Imre Kopits, M.D.	
22e. ADDRESS Spring Grove State Hospital						22f. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 30/68		23c. NAME OF CEMETERY OR CREMATORY Park		23d. LOCATION (City or Town) (County) (State) Dorchester Mem. Cambridge Md.		23e. REC'D BY REGISTRAR APR 30 1968	
24 FUNERAL DIRECTOR Philip Herwig Sons						25a REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
30M REV 1/68

MD 265

1

35263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Anna (Daisy) Middle (FANNOSK) Last Ivanauskas			2a. DATE OF DEATH Month April Day 9, Year 1968		2b. HOUR 9:15 a. M
3 SEX female	4 RACE white	5 DATE OF BIRTH Dec. 1894	6 AGE (n years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Lithuania	7b. CITIZEN OF WHAT COUNTRY? Lithuania	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b COUNTY Balto.	13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 807 Woodward Street	
14 FATHER'S NAME First Stanley Middle Kanchis Last			15. MOTHER'S MAIDEN NAME First Marsella Middle Milan Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO 2/5-01-0581	17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of heart 4107- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (this hospital) attended the deceased from March 6, 1954, to April 9, 1968, that (I) (we) last saw the deceased alive on April 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Vincent M. Ruano M.D.	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED 4-9-68			
22d PHYSICIAN'S NAME (Type) Vincent Ruano, M.D.	22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-11-68	23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem	23d. LOCATION (City or Town) Baltimore, Md.	(County)	(State)
24 FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins St	ADDRESS	25a. REC'D BY REGISTRAR DATE APR 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

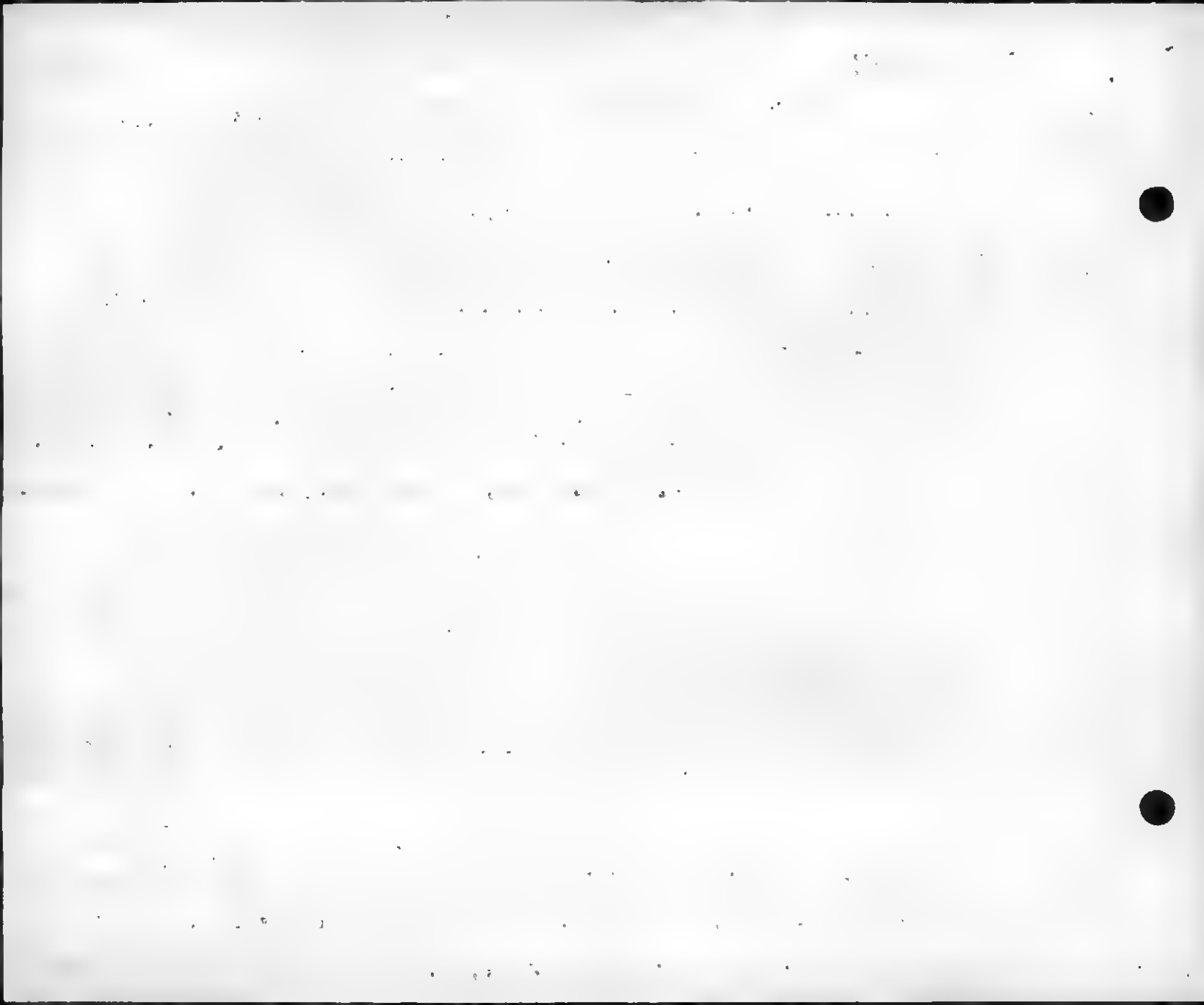
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-15 (4)
30M REV. 1-68

MD 262

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First Robert	Middle Lester	Last Jenkins	2a. DATE OF DEATH Month Day Year April 1st, 1968		2b. HOUR M
3 SEX male		4 RACE white		5. DATE OF BIRTH March 13, 1901		6 AGE (In years last b'day) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. D.C.=		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) laborer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Wash. D.C.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Randall Jenkins		15 MOTHER'S MAIDEN NAME First Middle Last Eva m. Lynch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579-09-3912		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) With irretractable Ht. Failure Arteriosclerotic, Cardiovascular Ht. Dis. 4127 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, Generalized, senile. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days. 3 years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) +							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (this hospital) attended the deceased from Oct. 19 , 19 67 , to April 1 , 19 68 , that (we) last saw the deceased alive on April 1 , 19 68 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did not) view the body after death							
22b. SIGNATURE <i>Anthony J. Young</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 4-1-68			
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 4, 68		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d. LOCATION (City or Town) (County) (State) Potestville, Maryland	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i> ADDRESS 1661-Gd. Hope Rd. SE Wash., D.C.				25a. RECD BY REGISTRAR DATE APR 3 - 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

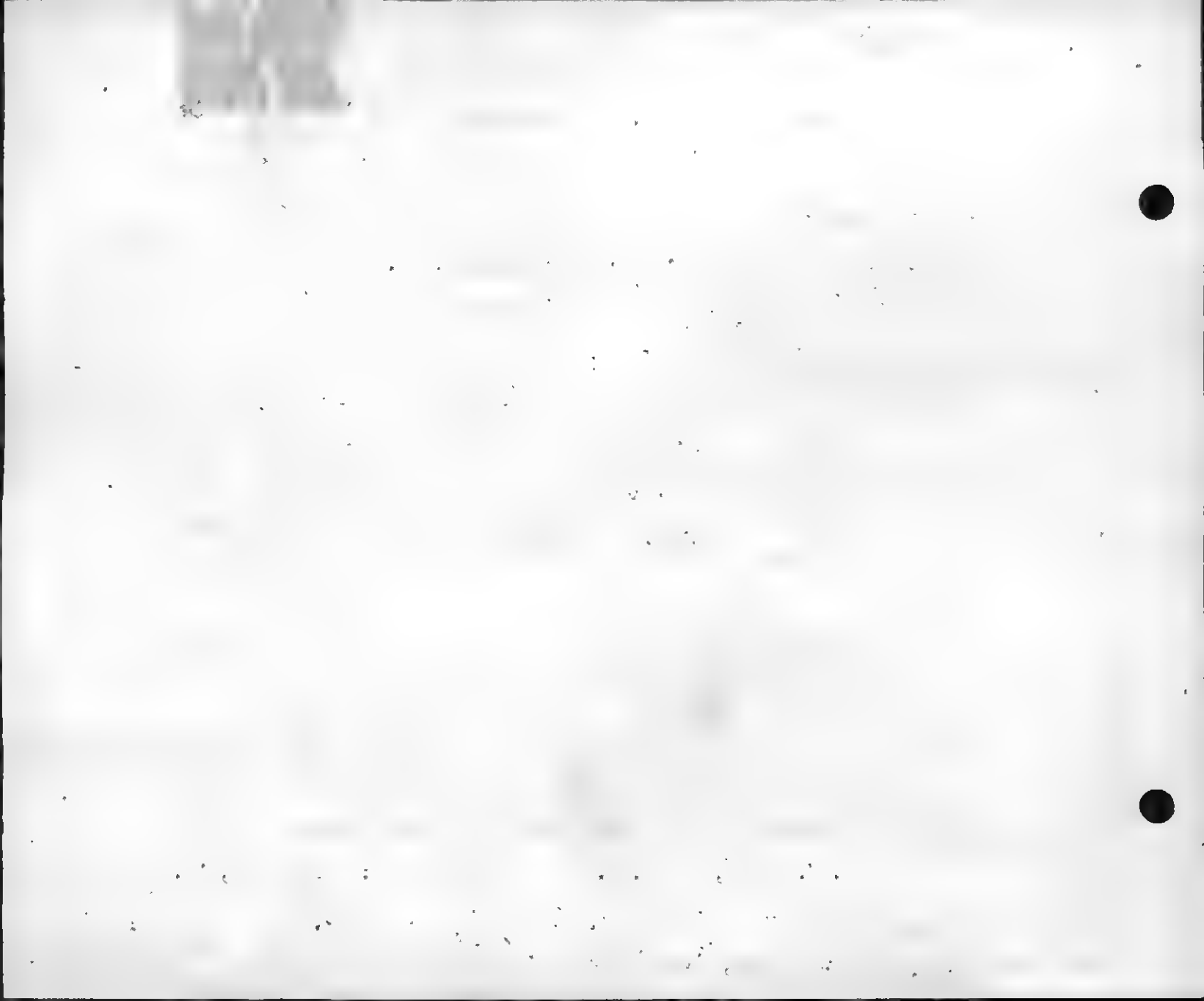


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
Julia C. Jennings									4 Month 15 Day 68		11:30A M		
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		white		Oct 23, 1957				80 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> -DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Baltimore, Md.		U.S.A.				Baltimore							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Randallstown		Liberty Rd; Randallstown, Md.				Homemaker		None					
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Md.		Baltimore		Baltimore 21234				1150 Rowan Court					
4 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last	
Thomas M. Corey									Lula Shewalter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address							
No		212-45 3004		Lucy J. Graham		1150 Rowan Court Baltimore 21234							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS. 2 day 10 yrs.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year P.M.											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from FEB 1967, to APR. 15 1968, that (I) (we) last saw the deceased alive on 4-15-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED											
R. V. Houck, Jr. M.D.		4-15-68											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
R. V. Houck, Jr; M. D.		Liberty Rd; Eldersburg, Md.											
23a BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		4-18-68		Maple Hill		Bluefield		Va					
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Graham Funeral Home, Bluefield, Va.		578 S. 1st St.		DATE APR 19 1968		Charles Judge							

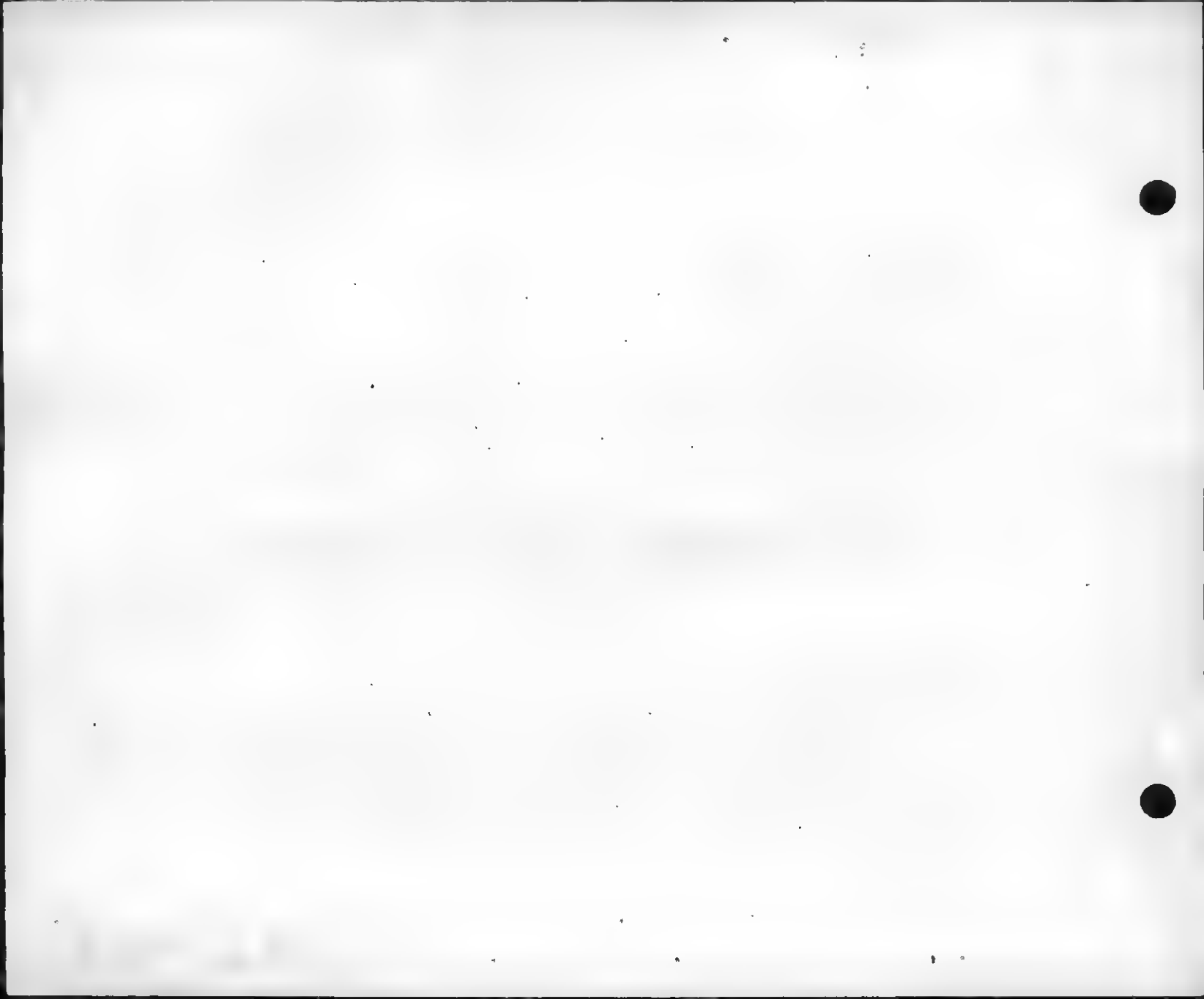


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <i>William Fell Johnson</i>						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <i>4</i> Day <i>13</i> Year <i>68</i>		2b HOUR <i>5:00</i> P.M.			
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>8-16-1884</i>		6 AGE (In years last birthday) <i>83</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.	
7a BIRTHPLACE (State or foreign country) <i>BALTO, MD</i>				7b CITIZEN OF WHAT COUNTRY? <i>USA</i>				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore Co.</i> Md	
10 CITY OR TOWN OF DEATH <i>TOWSON</i>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>St. Joseph Hosp.</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>LAWYER</i>		12b KIND OF BUSINESS OR INDUSTRY <i>LAW</i>	
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>MD</i>				13b COUNTY <i>BALTO.</i>		13c CITY OR TOWN <i>BROOKLANDVILLE</i>		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First <i>ROBERT</i> Middle <i>W.</i> Last <i>JOHNSON</i>						15 MOTHER'S MAIDEN NAME First <i>JULIA</i> Middle <i>W. H.</i> Last <i>BRACK</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes, no, or unknown</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <i>213-48-5406</i>		17 INFORMANT ADDRESS <i>DR. ROBERT W JOHNSON BALTO, MD</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>2164</i>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 ALTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <i>5:00 PM 4.13 19 68</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or, Part 2, Item 18.) <i>Passed stop sign struck other vehicle</i>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>street</i>		21f LOCATION Street or RFD No. City or Town County State <i>Manor Road Jarrettsville pike Baltimore Co. MD</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Werner H. Spitz</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <i>4.14.68</i>			
EXAMINER'S NAME (Type) <i>Wetner G. Spitz</i>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b DATE <i>4-16-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. Thomas'</i>		23d LOCATION (City or Town) (County) (State) <i>Garrison Forest Md.</i>			
24 FUNERAL DIRECTOR ADDRESS <i>H.W.Jenkins & Sons Co. 4905 York Rd.</i>						25a REC'D BY REG. STRAR <i>APR 16 1968</i>		25b REGISTRAR'S SIGNATURE <i>John J. Judge</i>			

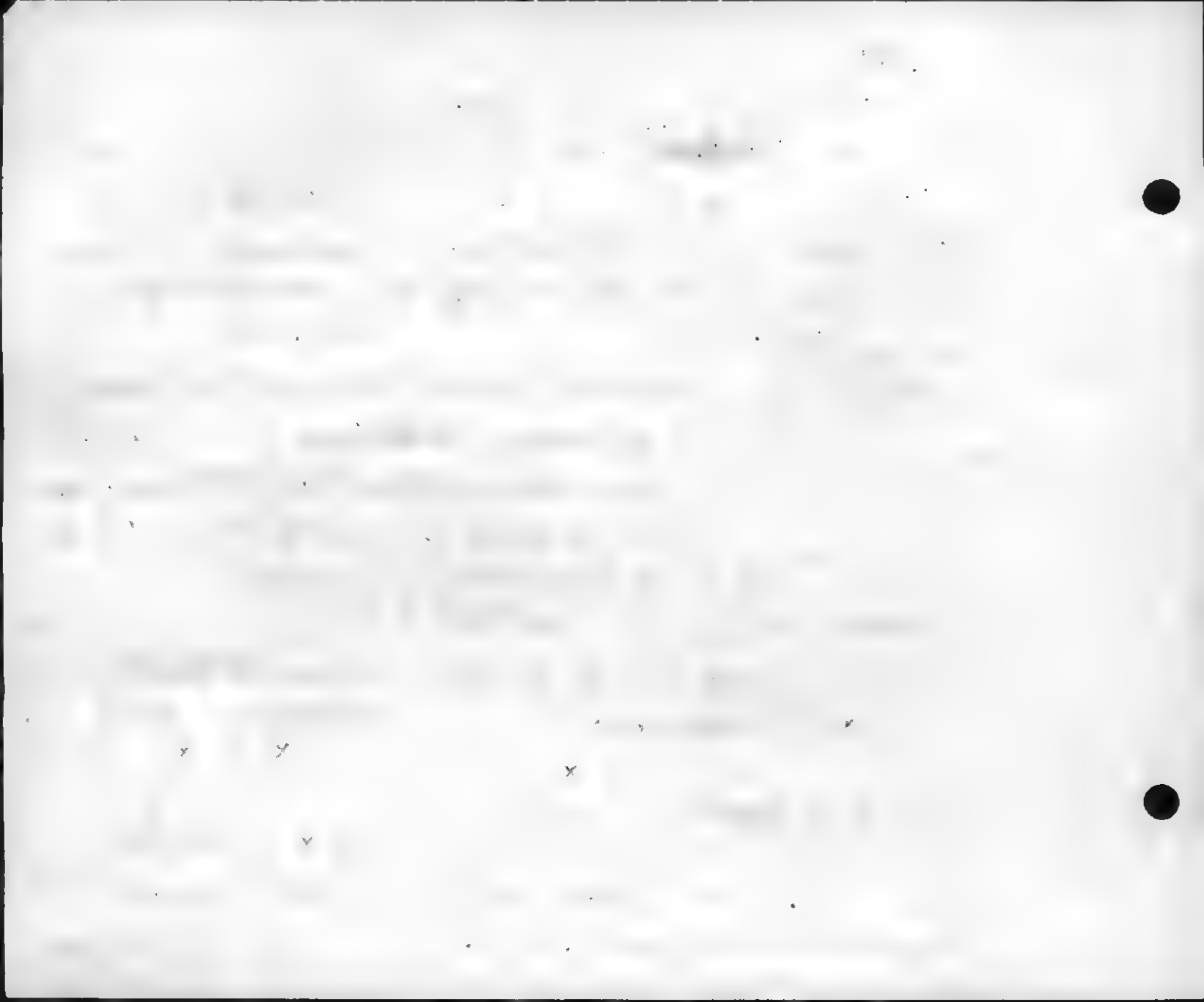


FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) EFFIE			First M.			Middle JONES			Last			2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month 4 Day 1 Year 1968			2b. HOUR 2 P														
3 SEX F			4 RACE W			5. DATE OF BIRTH 8-23-1891			6 AGE (In years last birthday) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			2c. DATE PRONOUNCED DEAD Month 4 Day 1 Year 1968			2d. HOUR 2 P								
7a. BIRTHPLACE (State or foreign country) Ind.						7b. CITIZEN OF WHAT COUNTRY? U.S.A						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH Balt. Co.											
10. CITY OR TOWN OF DEATH Int. Wilson						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Int. Wilson						12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife						12b. KIND OF BUSINESS OR INDUSTRY None											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ind.						13b. COUNTY Dorchester Cambridge						13c. CITY OR TOWN Cambridge						3d. INSIDE CITY - MISS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET AND NUMBER 406 Light St					
14. FATHER'S NAME First Samuel M. Middle Merodith Last						15. MOTHER'S MAIDEN NAME First Angie N. Middle Cannon Last																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Ind.						16b. SOCIAL SECURITY NO 2-14-07-9197						17. INFORMANT Int. Wilson Records - Int. Wilson Ind.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism. DUE TO, OR AS A CONSEQUENCE OF (b) Trans Cervical Fracture of RT Femur 1 mo. DUE TO, OR AS A CONSEQUENCE OF (c) Far Advanced Pulmonary The. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1 1/2 yrs																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterio Sclerotic Heart Disease																													
19a. DATE OF OPERATION Mar 18 '68						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fractured Femur						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month Day, Year Mar 1 1968						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell to floor going from bed to bathroom.																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Int. Wilson Hosp.						21f. LOCATION Street or R.F.D. No. Int. Wilson City or Town Balt. County Ind. State Ind.																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE D. D. Caples						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 4/1/68																	
EXAMINER'S NAME (Type) D.D. CAPLES, M.D.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
						ADDRESS 6 HAMMER Rd. - REISTERS TOWN, Md. 21136																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE Apr. 3, 1968						23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park						23d. LOCATION (City or Town) Cambridge (County) Maryland (State)											
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland						ADDRESS						25a. REC'D BY REGISTRAR 4 - 1968						25b. REGISTRAR'S SIGNATURE Charles Judge											



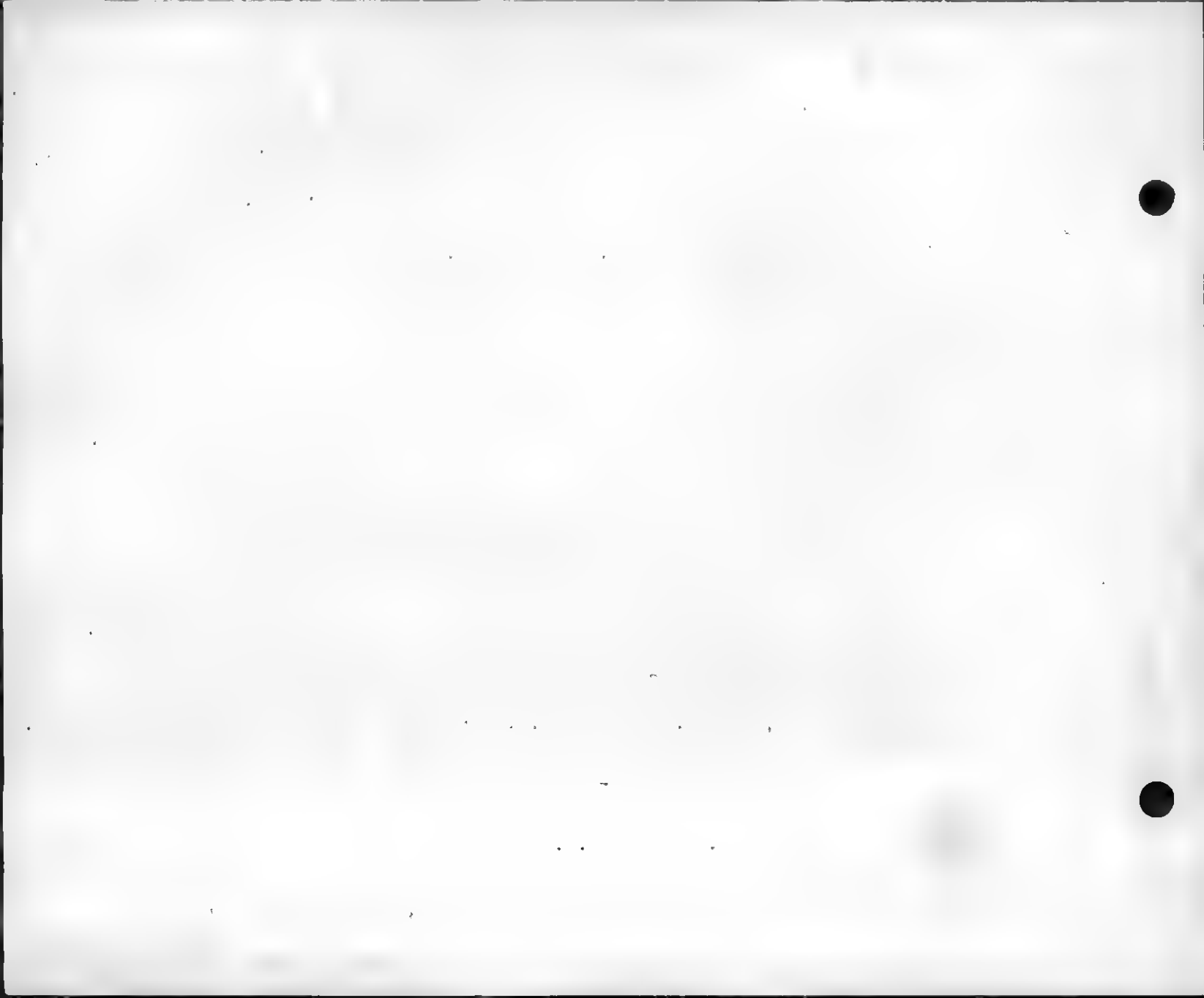
FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year			2b. HOUR
SHERRILL			LLOYD	JONES	2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year			2d. HOUR	
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN	2c. DATE PRONOUNCED DEAD Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year	2d. HOUR
Male	White		54 YRS.					April 6, 1968	6:50 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Cockeysville				St. Joseph Hosp.		BALTIMORE			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cockeysville			St. Joseph Hosp.						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
									(Unknown)
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 4:50 P.M. 4-6 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Sitting on R.R. tracks			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) R.R. tracks			21f. LOCATION Street or R.F.D. No. City or Town County State R.R. marker N-152 W. end of Cockeysville Baltimore Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Springate			M.D. Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED April 7, 1968
EXAMINER'S NAME (Type)						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 4-30-68			23c. NAME OF CEMETERY OR CREMATORY Md. Med. School			23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR DATE MAY 2 1968		25b. REGISTRAR'S SIGNATURE Charles Springate	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2, 3 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2267

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) ELIZABETH			First Middle Last			2a DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> April 3, 1968			2b HOUR 10:15		
3 SEX Female			4 RACE White			5 DATE OF BIRTH Oct 22 1919			6 AGE (In years last birthday) 48 YRS		
7a BIRTHPLACE (State or foreign country) West Va.			7b CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School Nurse			12b KIND OF BUSINESS OR INDUSTRY Balto County		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c CITY OR TOWN Townson			13d. USUAL CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME Owen Milton Hook			First Middle Last			15 MOTHER'S MAIDEN NAME Bertie Jane McLaughlin			First Middle Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b SOCIAL SECURITY NO 236-24-4364			17 INFORMANT Stephen Kaminitzky			ADDRESS 8436 Pleasant Plains Rd.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of Berry Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 33										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum			EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4-3-68		
23a BURIAL CREMATION REMOVAL (Specify) Burial			23b DATE 4/7/68			23c NAME OF CEMETERY OR CREMATORY Holy Trinity Cem.			23d LOCATION (City or Town) (County) (State) Elkridge, Maryland		
24 FUNERAL DIRECTOR Dippel Bro's Inc. 1800 E. Lombard St. 21231						ADDRESS			25a REC'D BY REG STRAR APR 9 - 1968		
									25b REG STRAR'S SIGNATURE J. Charles Judge		



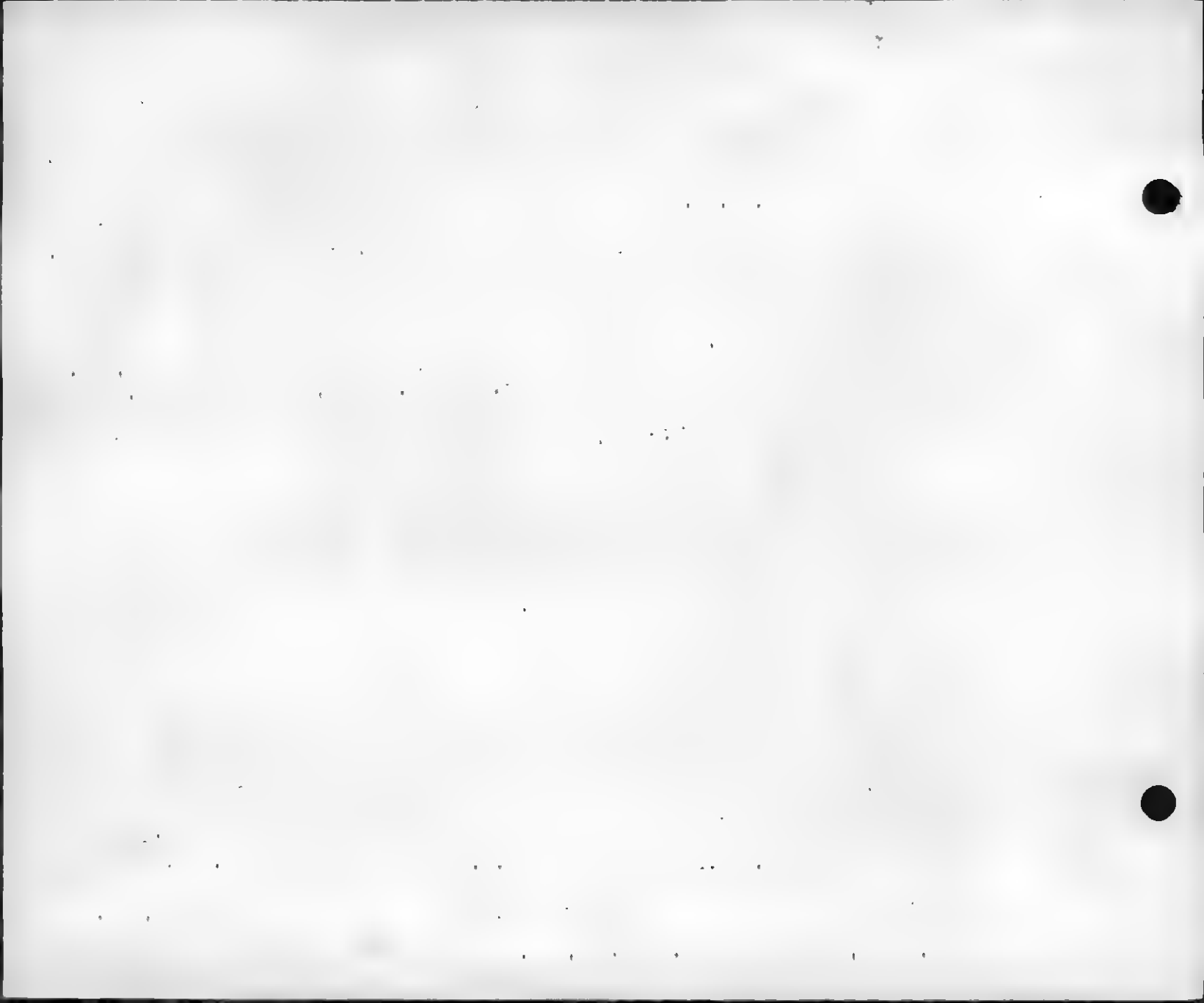
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

128

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) Paul Peter Katchmere			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month April Day 25 Year 1968			2b HOUR 10A M			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3/2/02	6 AGE (In years last birthday) 66 YRS	7 UNDER 1 YEAR MONTHS DAYS 	8 IF UNDER 24 HRS HOURS MIN 	2c DATE PRONOUNCED DEAD Month April Day 25 Year 1968		2d HOUR 10A M	
7a BIRTHPLACE (State or foreign country) Poland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			
10 CITY OR TOWN OF DEATH Dundalk		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2625 Yorkway			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Carpenter		12b KIND OF BUSINESS OR INDUSTRY Owens Co.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b CITY OR TOWN Dundalk		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2625 Yorkway		
14 FATHER'S NAME First John Middle J. Last Katchmere			15 MOTHER'S MAIDEN NAME First Elizabeth Middle Last Subks			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16b SOCIAL SECURITY NO 180-07-0393			17 INFORMANT (Friend) Mrs. Anna E. McGee, 2 Admiral Blvd.						
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221									
19a DATE OF OPERATION 4/22/68			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Am			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. 19 P.M. 		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f LOCATION Street or R.F.D. No City or Town County State 					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> M.B. Davis ACTUAL SIGNATURE EXAMINER'S NAME (Type) Melvin B. Davis M.D. ADDRESS (Street, city, town, or county) 6800 Mornington Road Dundalk 4/26/68 CHIEF MED. CAL. EXAMINER <input type="checkbox"/> ASS. STANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> 22b DATE SIGNED 4/26/68 ADDRESS (Street, city, town, or county) Md. 21222									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4/29/68		23c NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a REC'D BY REGISTRAR DATE APR 30 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



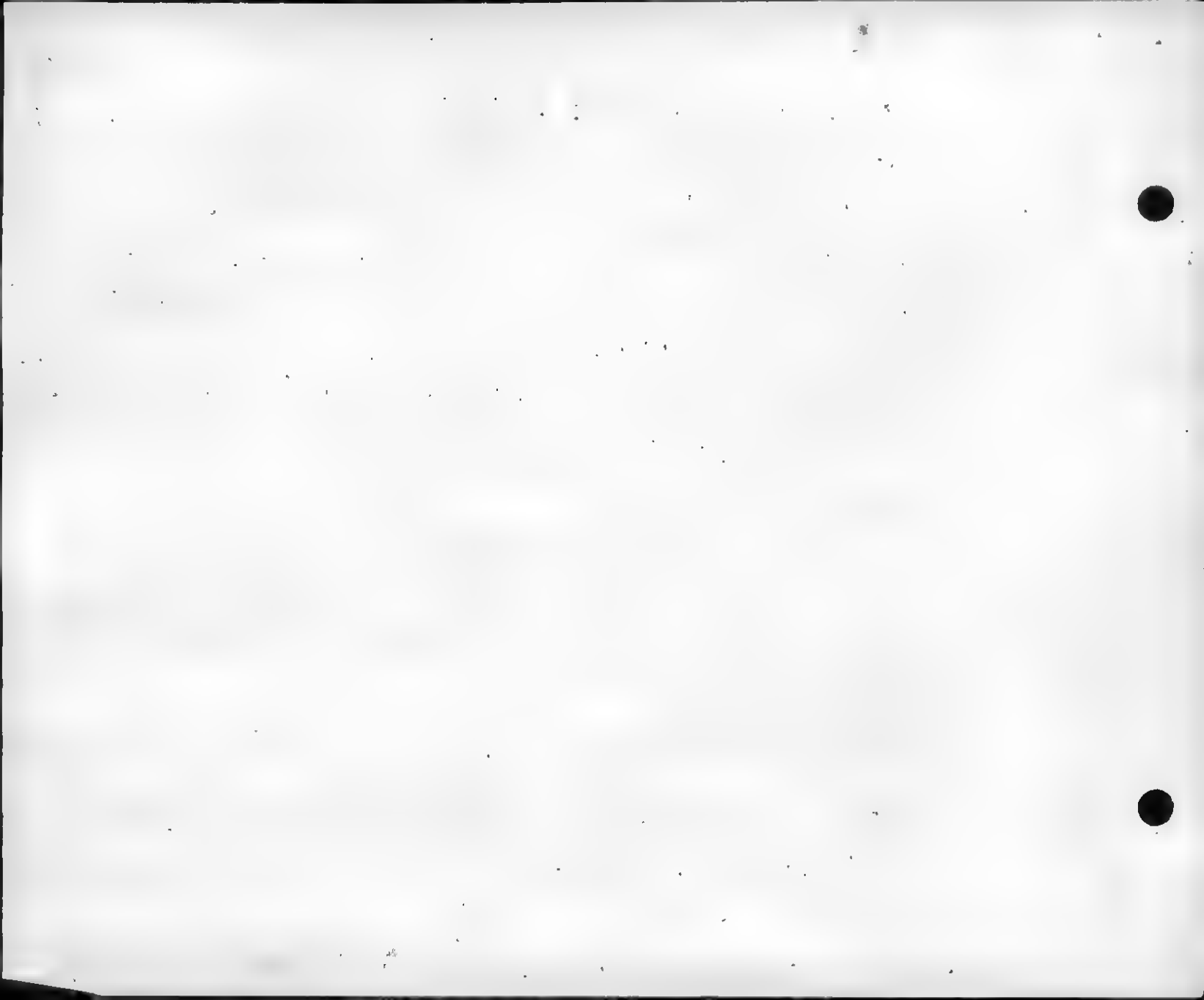
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20269
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) LILLIE RACHEL KATZ			2a. DATE OF DEATH Month April Day 24 Year 1968			2b. HOUR 1:15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH		6. AGE (In years last birthday) 70 YRS.	
7a. BIRTH-PLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3403 Cardinal Ct		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Pa		13b. COUNTY One		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 127 E 17th St.	
14. FATHER'S NAME First Herman Rubin Middle Borenson Last Robert			15. MOTHER'S MAIDEN NAME First Robert Middle ? Last ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 1171		17. INFORMANT Nathaniel Katz - 3403 Cardinal Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/24 , 19 68 , to 4/24 , 19 68 , that (I) (we) lost saw the deceased alive on 4/24 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leonard H. Golombek		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/24/68	
22d. PHYSICIAN'S NAME (Type) LEONARD H. GOLOMBEK		22e. ADDRESS LIBERTY ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE April 24/68		23c. NAME OF CEMETERY OR CREMATORY Cong. Beth Shalom		23d. LOCATION (City or Town) (County) (State) One, Pa.	
24. FUNERAL DIRECTOR Sol Lewinson & Sons		ADDRESS 6010 Reisterstown Rd		25a. REC'D BY REG. STRAR APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Robert J. M.D.

<div style="text-align: center;"> <p>35270</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div>												
1. DECEASED NAME (Type or print) RUTH First KATZ Middle Last						2a. DATE OF DEATH Month 4 Day 28 Year 1968			2b. HOUR 9 P. M.			
3 SEX F.		4 RACE White		5 DATE OF BIRTH 2/9/1894			6 AGE (In years last birthday) 74 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) M.D.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md						
10 CITY OR TOWN OF DEATH Mount Wilson				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1727 White Oak Ave.,				
14. FATHER'S NAME First Leonard Middle Bell Last				15. MOTHER'S MAIDEN NAME First Delia Middle Bradford Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 215-54-4772		17. INFORMANT Address Records, Mt. Wilson State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Portal Vein Thrombosis Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF Infarction of small bowel (ileum) (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF Pulmonary emphysema (c) Pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary emphysema												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4/3/1968 to 4/28/1968 , that (I) (we) last saw the deceased alive on 4/28/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Newcomer DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/68		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.				23d. LOCATION (City or Town) (County) (State) Balto. Md.				
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.						25a. REC'D BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



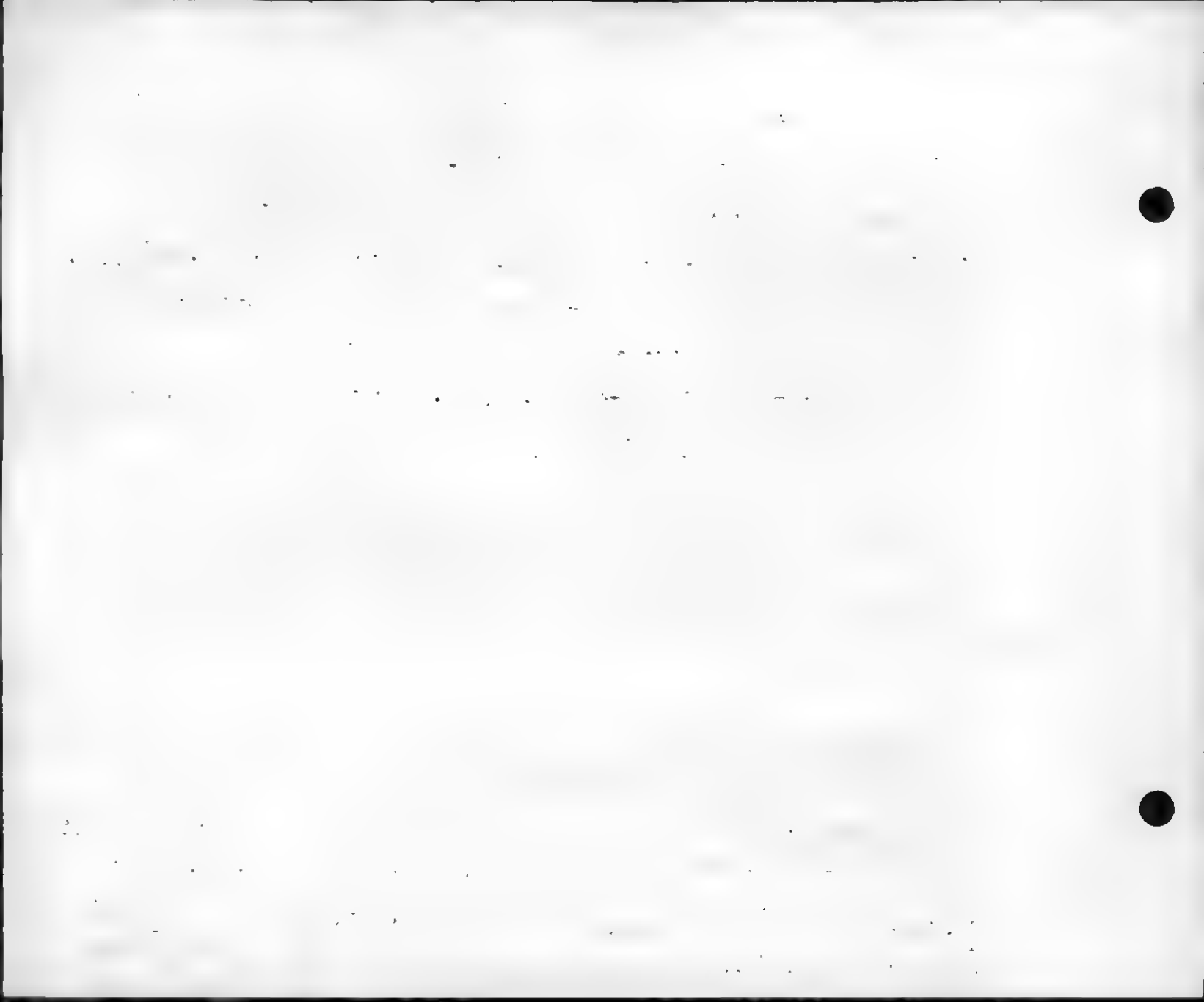
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151-1
30M REV 1-59

MD 271
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR A.M.	
Michael		F.		KELLEY	April 18, 1968		11:30 M	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS	
Male	White	August 27, 1904			63 YRS.		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Connecticut		U.S.A.				Baltimore Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Towson		ST. JOSEPH HOSPITAL			Community coordinator		Balto City	
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b COUNTY		13c CITY OR TOWN		13d NS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		- ✓		Baltimore				4112 Mary Ave.
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
John				Kelley	Margaret Colon			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO.		17 INFORMANT Address				
No		214-40-4475		Evelyn M. Kelley 4112 Mary Avenue 21206				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
+ 201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No		City or Town	County State
22a. I certify that (X) (this hospital) attended the deceased from 4/18/1968, to 4/18/1968, that (X) (we) last saw the deceased alive on 4/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Camilo Z. Tomboc						22c. DATE SIGNED April 18, 1968		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Camilo Z. Tomboc		7620 York Rd., Towson, Md. 21204						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
BURIAL		4-22-68		LONDON PARK CEMETERY		3001 FEDERICK RD. MARYLAND		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE		
DIPPEL BROTHERS, INC.		7110 BALAIR ROAD		APR 22 1968		Camilo Z. Tomboc		

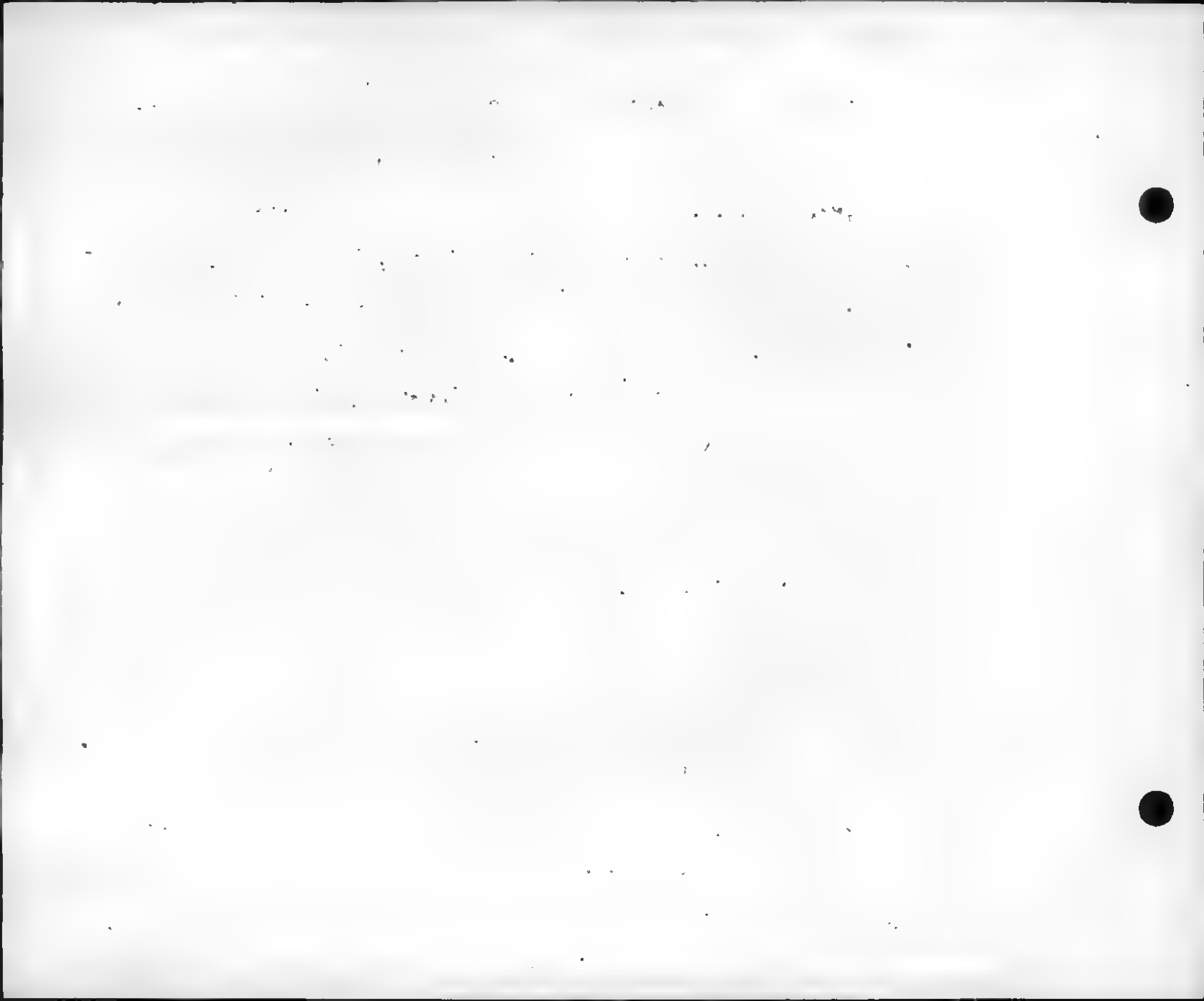


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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First THOMAS		Middle WALTER		Last KELLEY (Kelly)		2a. DATE OF DEATH April Month 2 Day 1968		2b. HOUR 9:p M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH November 6, 1905		6 AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Vienna, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospita. give street address) St. Joseph Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY EMERSON DRUG CO			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3004 Parktowne Rd.			
14. FATHER'S NAME First Middle Last THOMAS J. KELLEY				15. MOTHER'S MAIDEN NAME First Middle Last IDA MAE BRAMBLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 215-01-0518		17 INFORMANT Address MRS. MARGARET E. KELLEY (SAME)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) (c) <u>Endotoxin Shock</u> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetic Ketoacidosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from April 1, 1968, to April 2, 1968, that (X) (we) last saw the deceased alive on April 2, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death											
22b. SIGNATURE Jose Nepomuceno						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/2/68			
22d. PHYSICIAN'S NAME (Type) Jose Nepomuceno, M.D.						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-6-1968		23c. NAME OF CEMETERY OR CREMATORY PARKVIEW CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.					
24. FUNERAL DIRECTOR J. Walter Condon						ADDRESS 5444 BELAIR RD		25a. REC'D BY REGISTRAR DATE APR 8 - 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-154
304a REG. 1/68

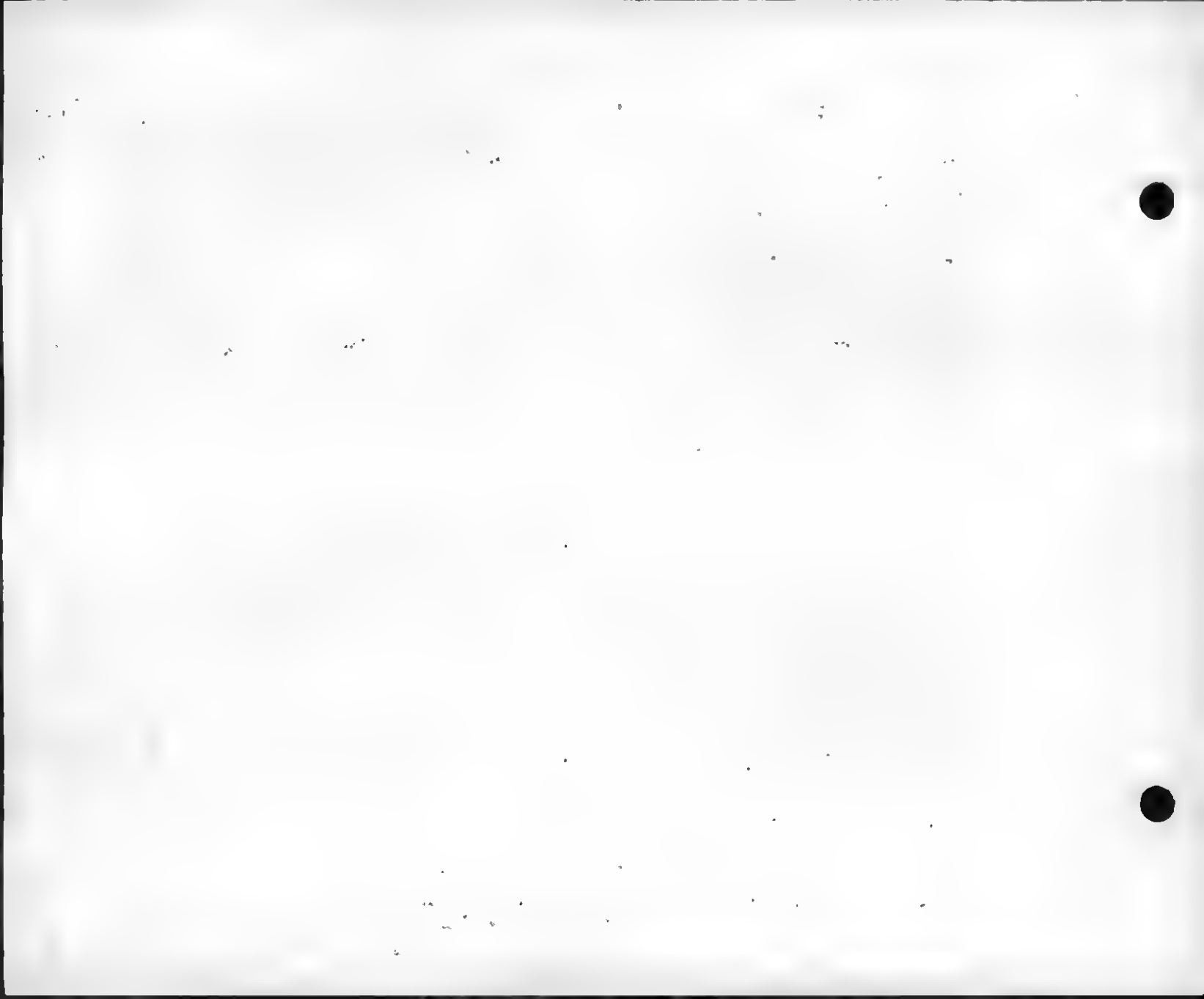
MD 273

05273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First Baby		Middle Girl		Last K E N T		2a DATE OF DEATH Month Day Year April 9, 1968			2b HOUR 8:15AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH April 9, 1968			6 AGE (In years last birthday) YRS MONTHS DAYS 1 45		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b CIT-ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore, Md						
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 130 Slade Ave.				
14 FATHER'S NAME First Middle Last Victor Kent				15. MOTHER'S MAIDEN NAME First Middle Last Patricia Ann Brigandi								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>1701</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature rupture of membranes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Premature separation of placenta</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>761</u>												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4/9/</u> , 19 <u>68</u> , to <u>4/9/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4/9/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>Warren W. Wurzbacher</u> M.D.				22c. DATE SIGNED April 10, 1968				22d. ADDRESS 6720 York Rd., Towson, Md. 21204				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <u>5/17/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore</u> <u>in the city</u>						
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE <u>MAY 20, 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

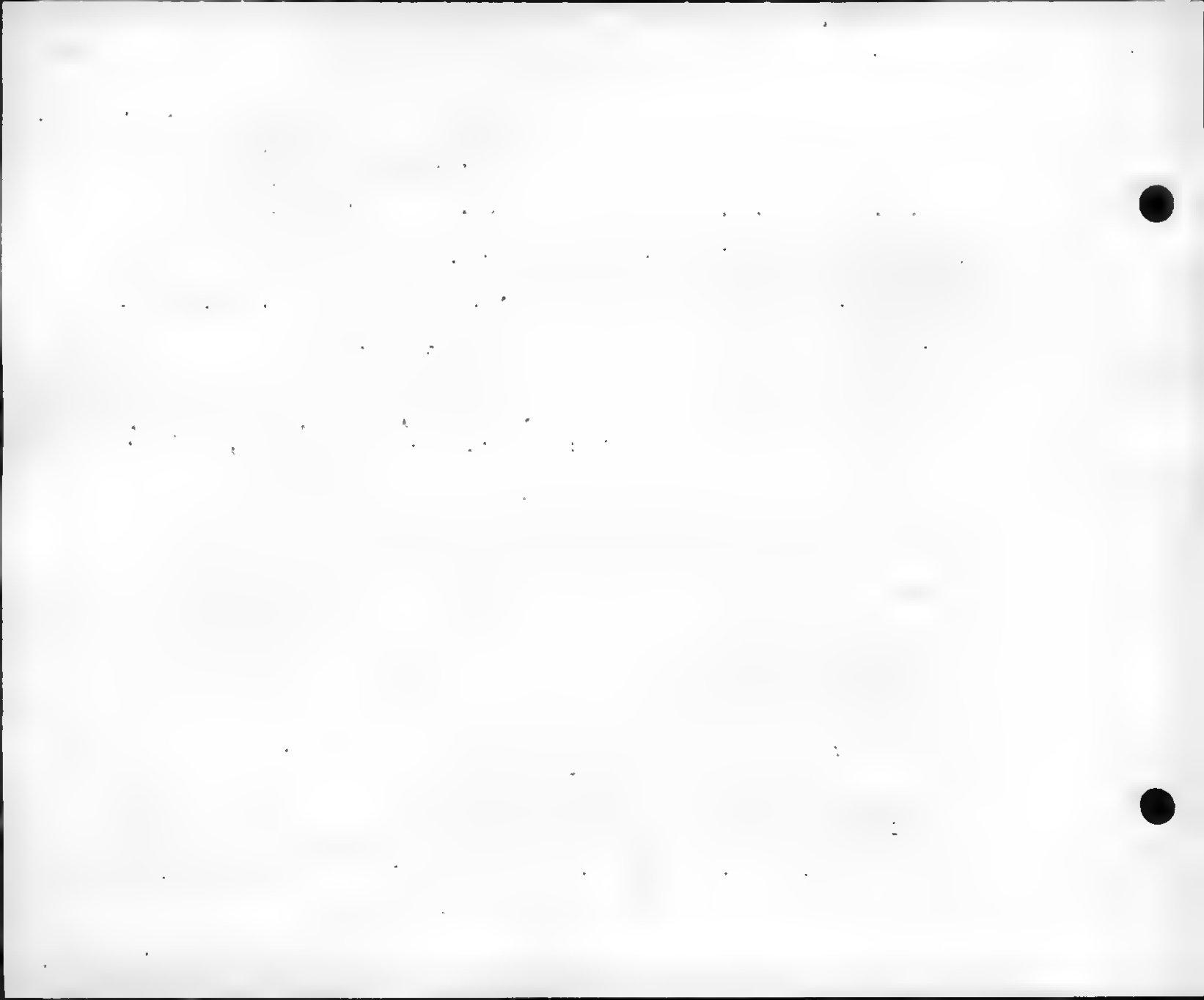
15274

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item # 23b & 23c film # G401 50

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Charles Leonard King			2a DATE OF DEATH Month April Day 22 , Year 1968		2b HOUR 3:50 M
3 SEX male	4 RACE Negro	5 DATE OF BIRTH Aug. 1, 1911		6 AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a BIRTHPLACE (State or foreign country) S. C.		7b CITIZEN OF WHAT COUNTRY? U. S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) 	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY 	13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 721 S. Hanover St.
14. FATHER'S NAME First Rich Middle King Last King			15. MOTHER'S MAIDEN NAME First Adelaide Middle Monroe Last Monroe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) upper Lobe Bronchus, with Metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of the Lung, left					
1621 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from May 26, 1967 , to April 22, 1968 , that (X) (we) last saw the deceased alive on April 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (do) (did not) view the body after death.					
22b SIGNATURE Anthony J. Young, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 4-22-68	
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 4/29/68		23c NAME OF CEMETERY OR CREMATORY Anatomy Board	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE Apr 25 1968	
				25b REGISTRAR'S SIGNATURE Charles Judge	

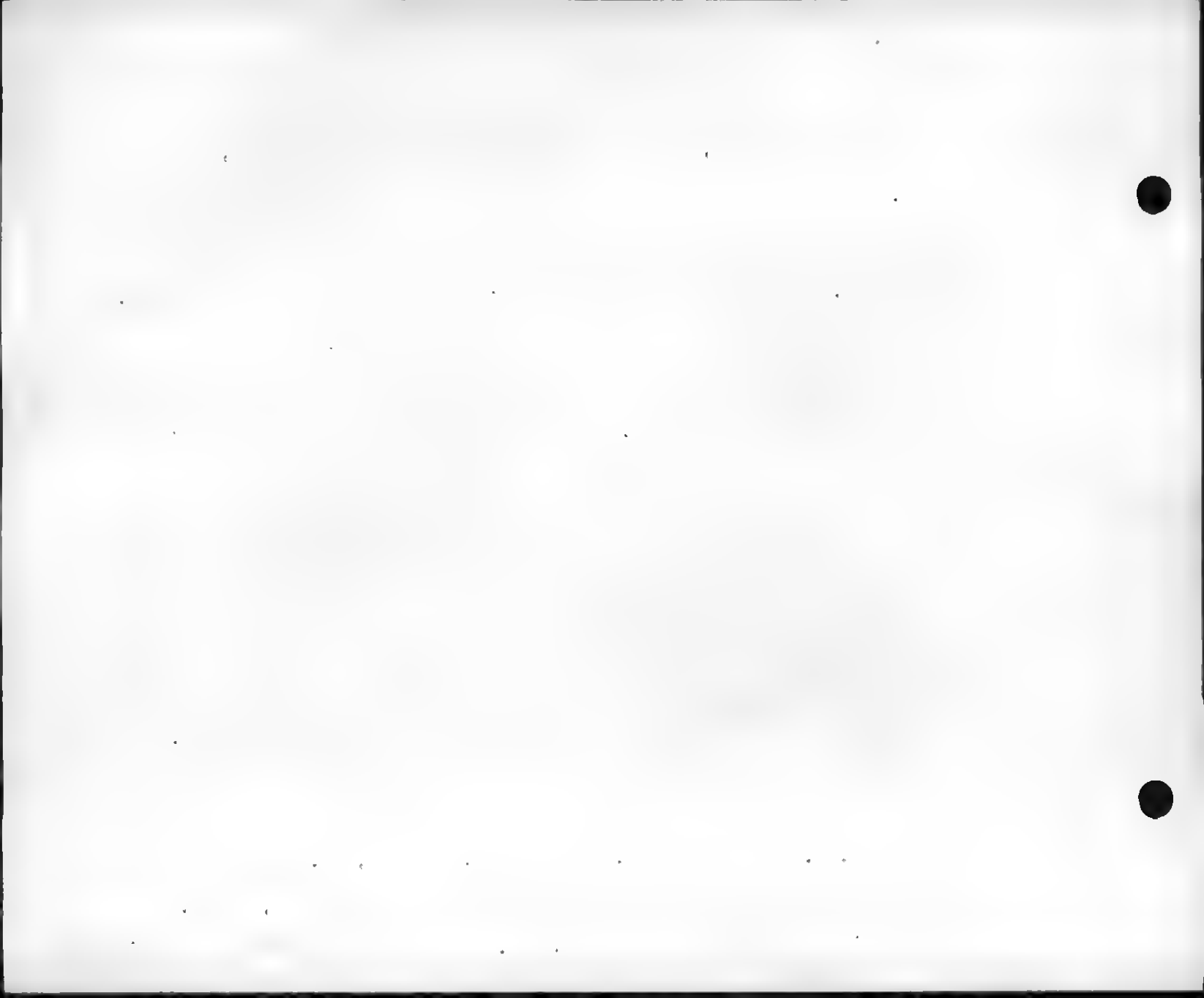


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) JAMES P. KLINE			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year 19			2b. HOUR M		
3 SEX Male		4. RACE White		5. DATE OF BIRTH July 3, 1896		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year April 15, 1968 19 8:35 PM	
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Essex			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1025 Eastern Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Miner			12b. KIND OF BUSINESS OR INDUSTRY Coal Mine		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Essex			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 1025 Eastern Ave.			14. FATHER'S NAME First Middle Last Nicholas Kline			15. MOTHER'S MAIDEN NAME First Middle Last Eliza Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. (If yes, give year or dates of service) WWI 191 09 0232HA			17. INFORMANT Anna Kline			ADDRESS Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF H.C.U.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Theo. C. Patterson M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/15/68		
EXAMINER'S NAME (Type) Theo. C. Patterson, M.D. 105 Main St. Baltimore, Md. 21202						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal						23b. DATE 4/17/68			23c. NAME OF CEMETERY OR CREMATORY Beck Funeral Home		
24. FUNERAL DIRECTOR Bruzdinski Funeral Home 1407 Eastern Ave.						23d. LOCATION (City or Town) (County) (State) Portage, Penna.					
25a. REC'D BY REGISTRAR DATE APR 18 1968						25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

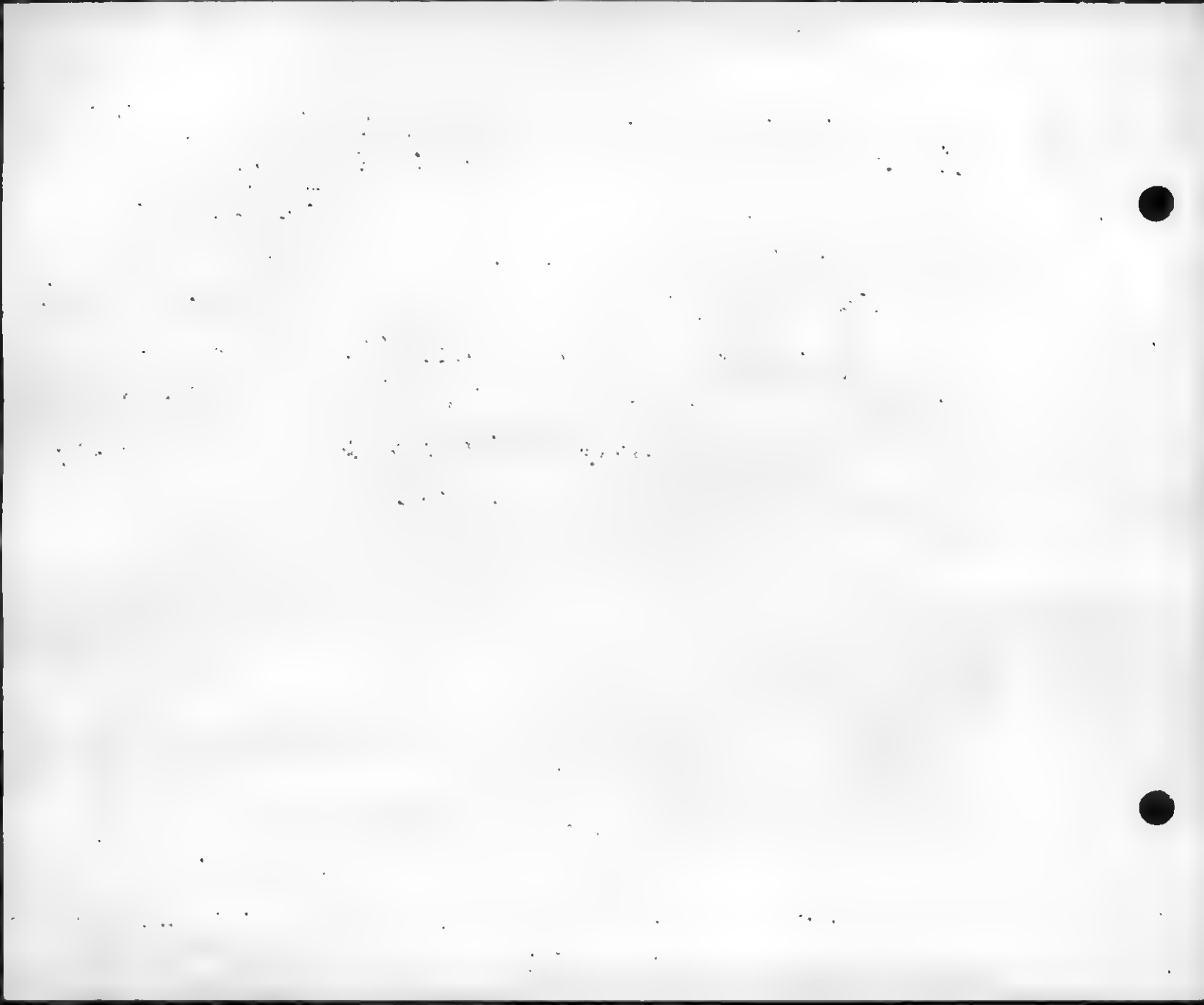
VR 1514
30M REV. 7-68

05279

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05279

1 DECEASED-NAME (Type or print) First Middle Last <i>St. Mary Rosasia Klinzing</i>			2a DATE OF DEATH Month Day Year <i>4 - 9 - 1968</i>		2b HOUR <i>4:45 PM</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>1-16-1946</i>	6 AGE (In years last birthday) <i>22</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <i>Germany</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>Baltimore</i> Md		
10 CITY OR TOWN OF DEATH <i>Glen Arm, Md.</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tal give street address) <i>Glen Arm Road</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Teacher</i>	12b KIND OF BUSINESS OR INDUSTRY <i>EDUCATION</i>		
13a USUAL RESIDENCE (Where deceased lived, if instit. or residence before admission) STATE <i>Md.</i>	13b COUNTY <i>Baltimore</i>	13c CITY OR TOWN <i>Glen Arm Rd.</i>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last <i>Michael Klinzing</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Amalia Frank</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b SOCIAL SECURITY NO. <i>320-54-9334</i>	17 INFORMANT Address <i>St. M. Kathleen Same</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary occlusion</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>11-10, 1966</i> , to <i>4-4-1968</i> , that (I) (we) last saw the deceased alive on <i>4-4-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Henry L. McCorkle MD</i>		DEGREE <i>MD</i>		22c DATE SIGNED <i>4-10-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>HENRY L. MCCORKLE MD</i>		22e ADDRESS <i>Phoenix, Maryland 21131</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>APRIL 11, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>SISTERS CEMETERY</i>	
23d FUNERAL DIRECTOR <i>RAYMOND C. CURRAN</i>		ADDRESS <i>817 SCARLETT DR TOWSON, MD 21204</i>		23e LOCATION (City or Town) (County) (State) <i>Glen Arm Balt Maryland</i>	
24a REC'D BY REGISTRAR <i>DATE APR 18 1968</i>		24b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (Rev. 4-7-68)

65277

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) MARIE First M. Middle KOENIG Last			2a. DATE OF DEATH Month APRIL Day 17 Year 1968		2b. HOUR 5 P.M.
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH Feb. 6, 1886	
6. AGE (In years last birthday) 82 YRS.		7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Baltimore 21212		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 513 Castle Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 513 Castle Drive			
14. FATHER'S NAME First Adam Middle D. Last Miller			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Reese Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 218-18-7940		17. INFORMANT Address Mr. Henry A. Koenig, Trappe, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. 4129 IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arterio sclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. no City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from June - 2 - 1967 , to April 17, 1968 , that (I) (we) last saw the deceased alive on April 11 - 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Earl L. Chambers - M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED April 19, 1968	
22d. PHYSICIAN'S NAME (Type) Earl L. Chambers - M. D.				22e. ADDRESS 4105 Liberty Hgts., Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) Baltimore, Maryland		(County) (State)			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland				25a. REC'D BY REGISTRAR DATE APR 23 1968	
				25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05281

1 DECEASED-NAME (Type or print) First HERMAN Middle A. Last KOHLHOFF		2a DATE OF DEATH Month April Day 8 Year 1968 2b HOUR 3:50 P M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH 2-27-89	6 AGE (in years last birthday) 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Baltimore Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md
10 CITY OR TOWN OF DEATH Baltimore	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Carpenter	12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Baltimore	13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First Richard Middle Kohlhoff Last Kohlhoff		15 MOTHER'S MAIDEN NAME First Harriett Middle Loudenslager Last Loudenslager	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b SOCIAL SECURITY NO -	
17 INFORMANT Mrs. Mary T. Kohlhoff		Address (Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism 450 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO, OR AS A CONSEQUENCE OF (c) -			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 465 X			
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 4-5- , 19 68 , to 4-8 , 19 68 , that (I) (we) last saw the deceased alive on 4-8- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE Paglinuan	DEGREE -	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 4-8-1968
22d. PHYSICIAN'S NAME (Type) Eodula Paglinuan Jr.		22e ADDRESS St Joseph Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4/12/68.	23c NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery	23d LOCATION (City or Town) (County) (State) Texas, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR APR 9 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



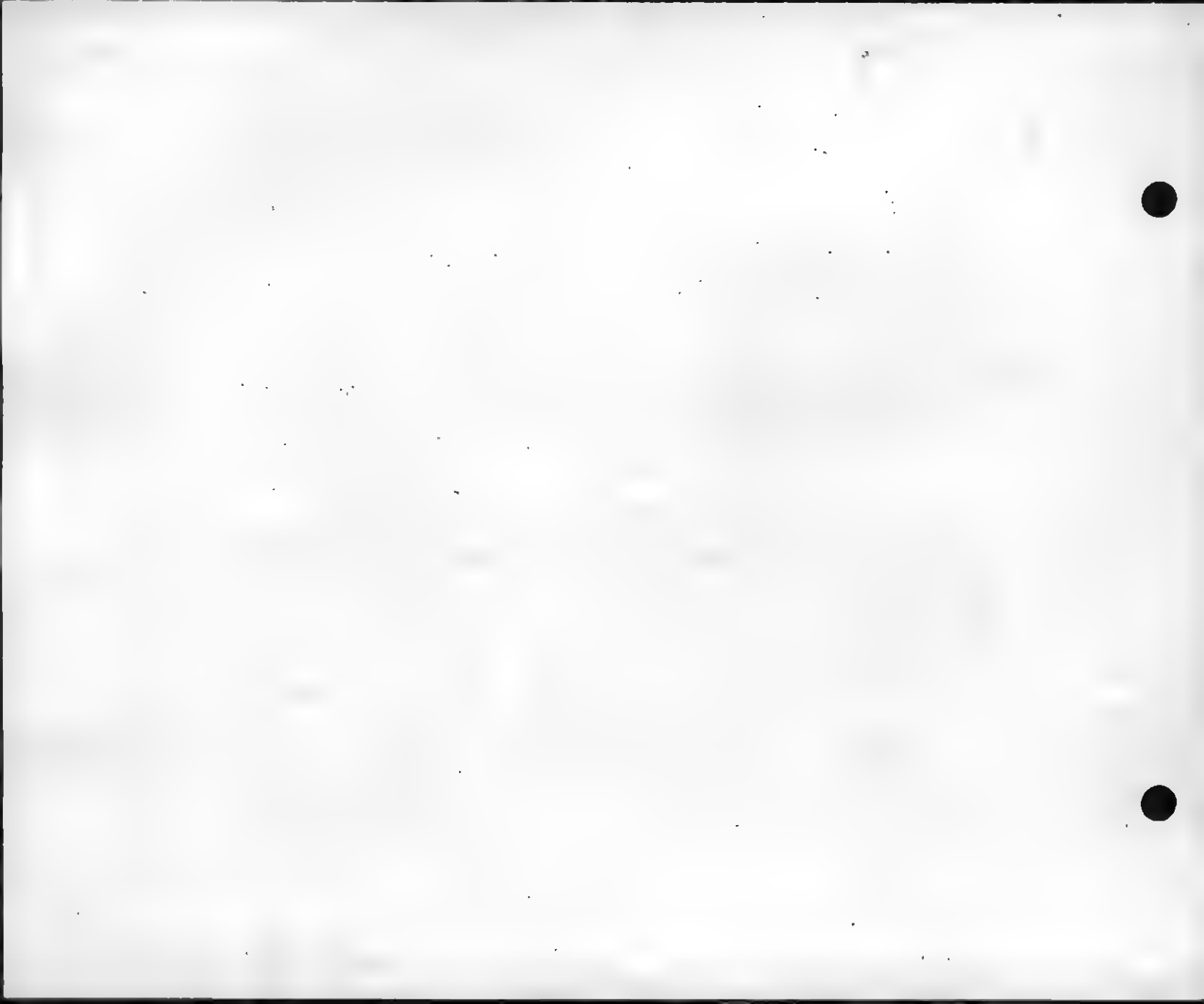
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First <i>Quincy</i> Middle <i>Heath</i> Last <i>Kopp</i>			2a. DATE KNOWN OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1968</i>			2b. HOUR Hour <i>2:00</i> PM			
3. SEX <i>F</i>	4. RACE <i>L</i>	5. DATE OF BIRTH <i>5-23-17</i>	6. AGE (in years last birthday) <i>50</i> YRS	7. UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8. UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>16</i> Year <i>1968</i>	2d. HOUR Hour <i>2:00</i> PM
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE</i>			MD
10. CITY OR TOWN OF DEATH <i>Randallstown Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Baltimore City General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Registered Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Physician</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>3216 Rolling Road</i>	
14. FATHER'S NAME First <i>Thomas H.</i> Middle <i>Low</i> Last <i>Low</i>				15. MOTHER'S MAIDEN NAME First <i>Myrtle</i> Middle <i>Low</i> Last <i>Low</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>527-28-5461</i>		17. INFORMANT <i>John Hannibal Kopp Jr.</i>		ADDRESS <i>3216 Rolling Rd Baltimore 21207</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Overdose of Meperidine (Buprenorphine)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>970?</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. ADJUSTED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i> State <i></i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>J. Nelson McKay</i>				M.D. <i>J. Nelson McKay, M.D.</i>		22b. DATE SIGNED <i>4/16/68</i>			
EXAMINER'S NAME (Type) <i>J. Nelson McKay, M.D.</i>				DEPUTY MEDICAL EXAMINER <i></i>		ADDRESS (Street, city, town, or county) <i></i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/18/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		(County) <i>Stn</i> (State) <i>Md</i>	
24. FUNERAL DIRECTOR <i>Koning Beyer - 8725 Fidelity Road Randallstown Md</i>				ADDRESS <i></i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	
				DATE <i>APR 19 1968</i>					

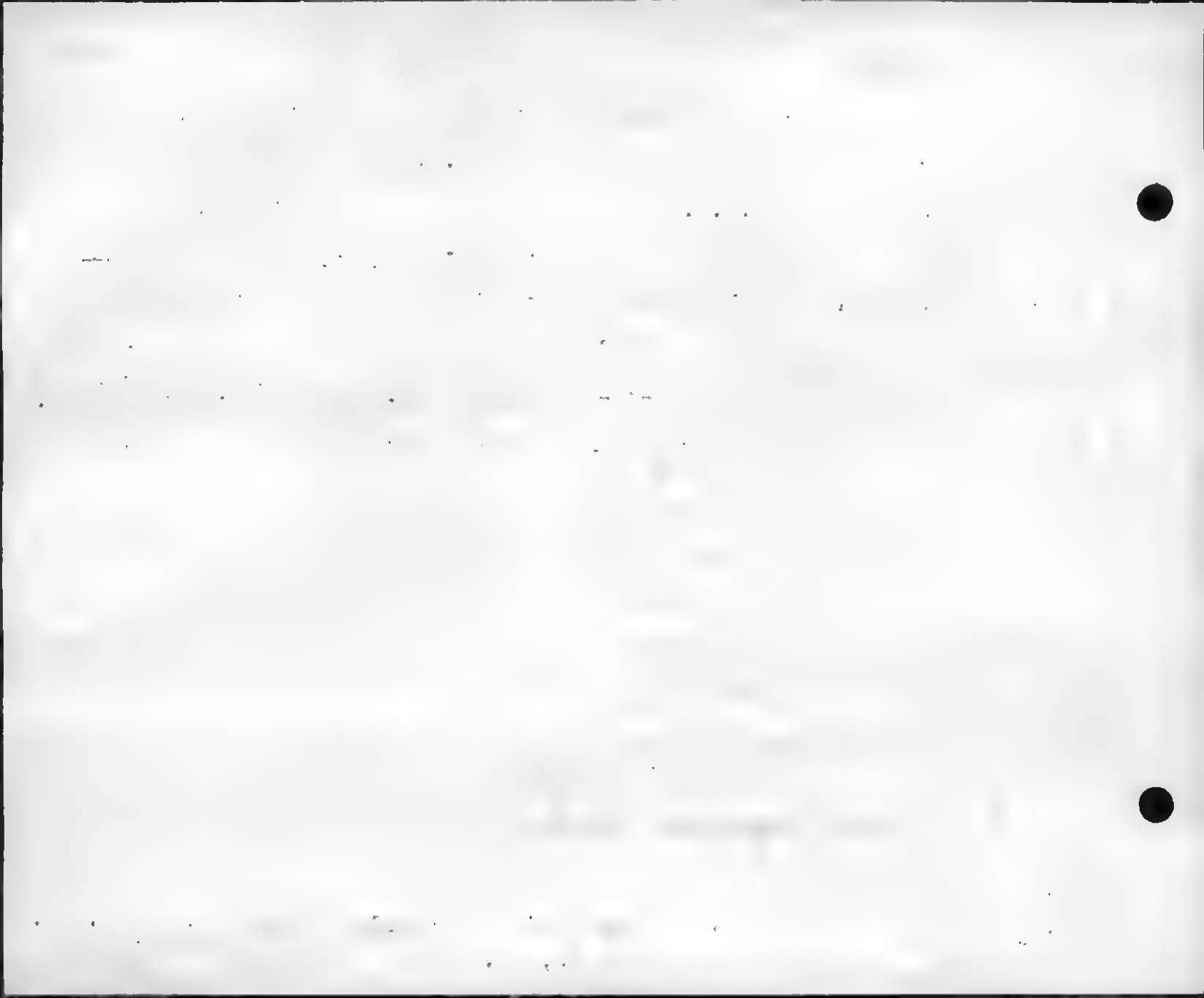


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the funeral director. The original should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Anna Louise Korman			2a. DATE OF DEATH Month Day Year April 7, 1968		2b. HOUR P M 2 P M
3 SEX Female	4 RACE White	5 DATE OF BIRTH Feb. 1, 1875		6 AGE (In years last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Reisterstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Berrymans Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Reisterstown	3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Berrymans Lane	
14 FATHER'S NAME First Middle Last Samuel France		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Murray			
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 217-48-6147		17 INFORMANT Address Charles W. Korman Berrymans Lane Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) none		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. none 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) none	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-16-45 , 19__, to 4-7-68 , 19__, that (I) (we) last saw the deceased alive on 3-21-58 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. D. Caples M.D.				22c. DATE SIGNED Apr. 9, 1968	
22d. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				22e. ADDRESS 6 Hanover Rd., Reisterstown, Md. 21136	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 10, 1968		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	
23d. LOCATION (City or Town) (County) (State) Reisterstown Balto., Md.					
24. FUNERAL DIRECTOR H. J. Schardt		ADDRESS Owings Mills, Md.		25a. REGISTERED DATE APR 10 1968	
25b. REGISTRAR'S SIGNATURE J. J. Judge					

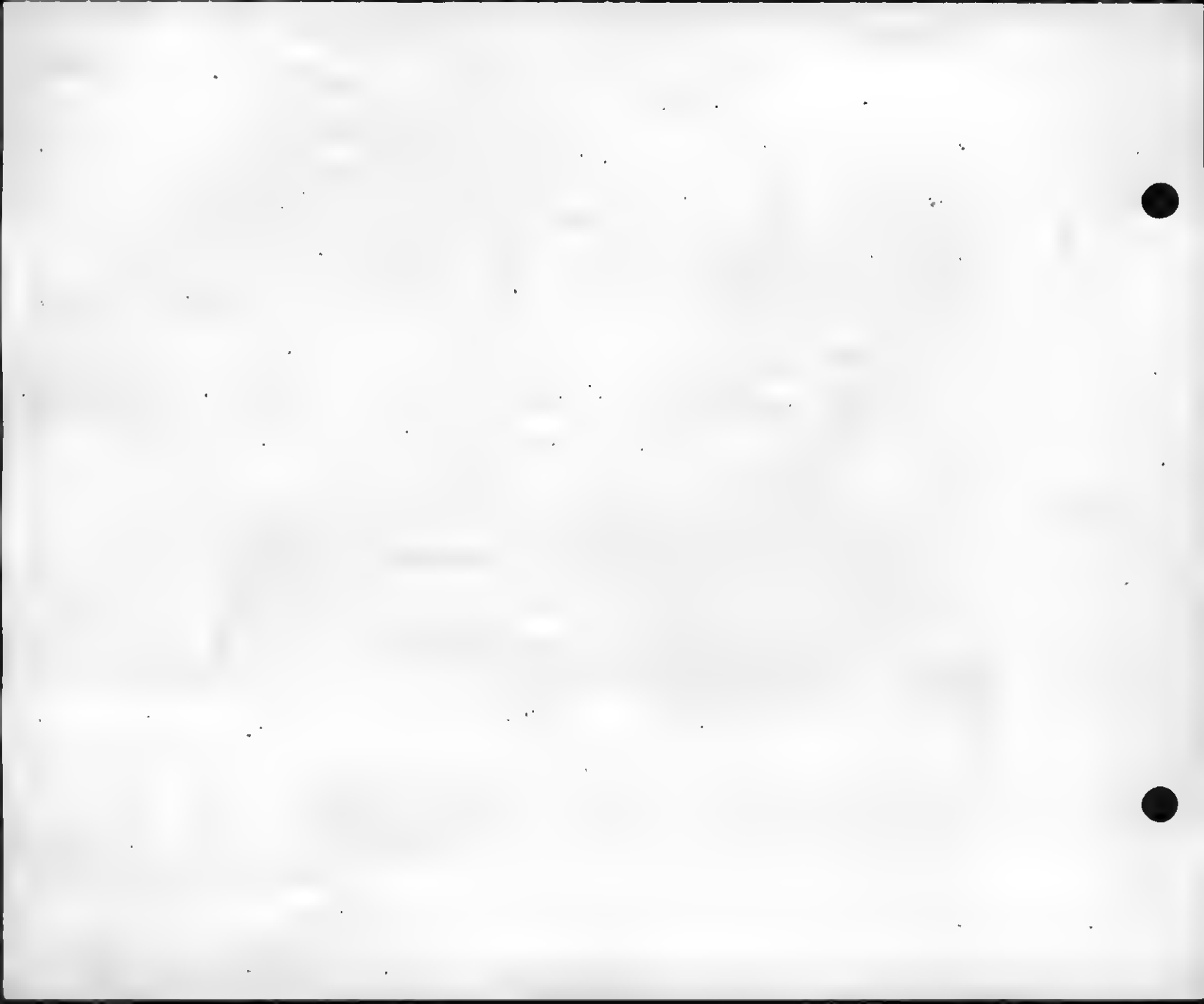


FOR STATE
HEALTH DEPT

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) LYNN First TITMSEN Middle KREEGER Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month APR Day 21 Year 1968 2b. HOUR 3:40 AM								
3 SEX M	4 RACE W	5 DATE OF BIRTH 11-17-39	6 AGE (in years last birthday) 28 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD APR 21 Day Year 1968 2d. HOUR 3:40 AM					
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) SALES MAN		12b. KIND OF BUSINESS OR INDUSTRY					
13a. U.S.A. RESIDENCE (Where deceased admitted) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN COCKEYSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET AND NUMBER 202 DUKE OF KENT LANE		14. FATHER'S NAME First JAMES S. Middle KREEGER Last		15. MOTHER'S MAIDEN NAME First DEBORAH Middle BROWN Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO 220-32-9941		17. INFORMANT NOEL D. KREEGER ADDRESS 202 DUKE OF KENT LANE							
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COMPOUND FRACTURE BASE OF SKULL X17.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 4/21 1968 HOUR A.M. 4 P.M. 4		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) DRIVER OF CAR							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HIGHWAY		21f. LOCATION Street or R.F.D. No. City or Town County State HARRISBURG EPNY RD. BALTO. MD.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-21-68							
EXAMINER'S NAME (Type) William A. Pillsbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
		ADDRESS (Street, City, Town or County) Towson									
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL	23b. DATE 4/25/68	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.	23d. LOCATION (City or Town) (County) (State) BALTIMORE MD.								
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 YORK RD. 21204		25a. REC'D BY REG. STAFF APR 25 1968	25b. REG. STAFF'S SIGNATURE Charles Judge						



FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) FREDERICK J. KROLL		First Middle Last		2a DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year APR 3 1968		2b HOUR 8:18 AM	
3 SEX M	4 RACE W	5 DATE OF BIRTH 7/13/05	6 AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month 4 - Day 3 Year 1968	
7a BIRTHPLACE (State or foreign country) MO.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTO	
10 CITY OR TOWN OF DEATH ESSEX		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 305 SO. TAYLOR		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY OIL	
13a J.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD.		13b. COUNTY BALTO		13c CITY OR TOWN ESSEX		13e STREET AND NUMBER 305 SO. TAYLOR	
14. FATHER'S NAME First Middle Last JACOB F. KROLL		15 MOTHER'S MAIDEN NAME First Middle Last DORA KACKER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) UNK		16b SOCIAL SECURITY NO 214-01-4587		17 INFORMANT ADDRESS FLORENCE KROLL ABOVE			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 422.1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home farm street factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) M.B. Davis MD.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 4/15/68			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4/16/68		23c NAME OF CEMETERY OR CREMATORY OLAK LAWN		23d LOCATION (City or Town) (County) (State) BALTO. MD.	
24 FUNERAL DIRECTOR ADDRESS J.G. CONNELLY SONS 300 MACE		25a REC'D BY REGISTRAR APR 8 - 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

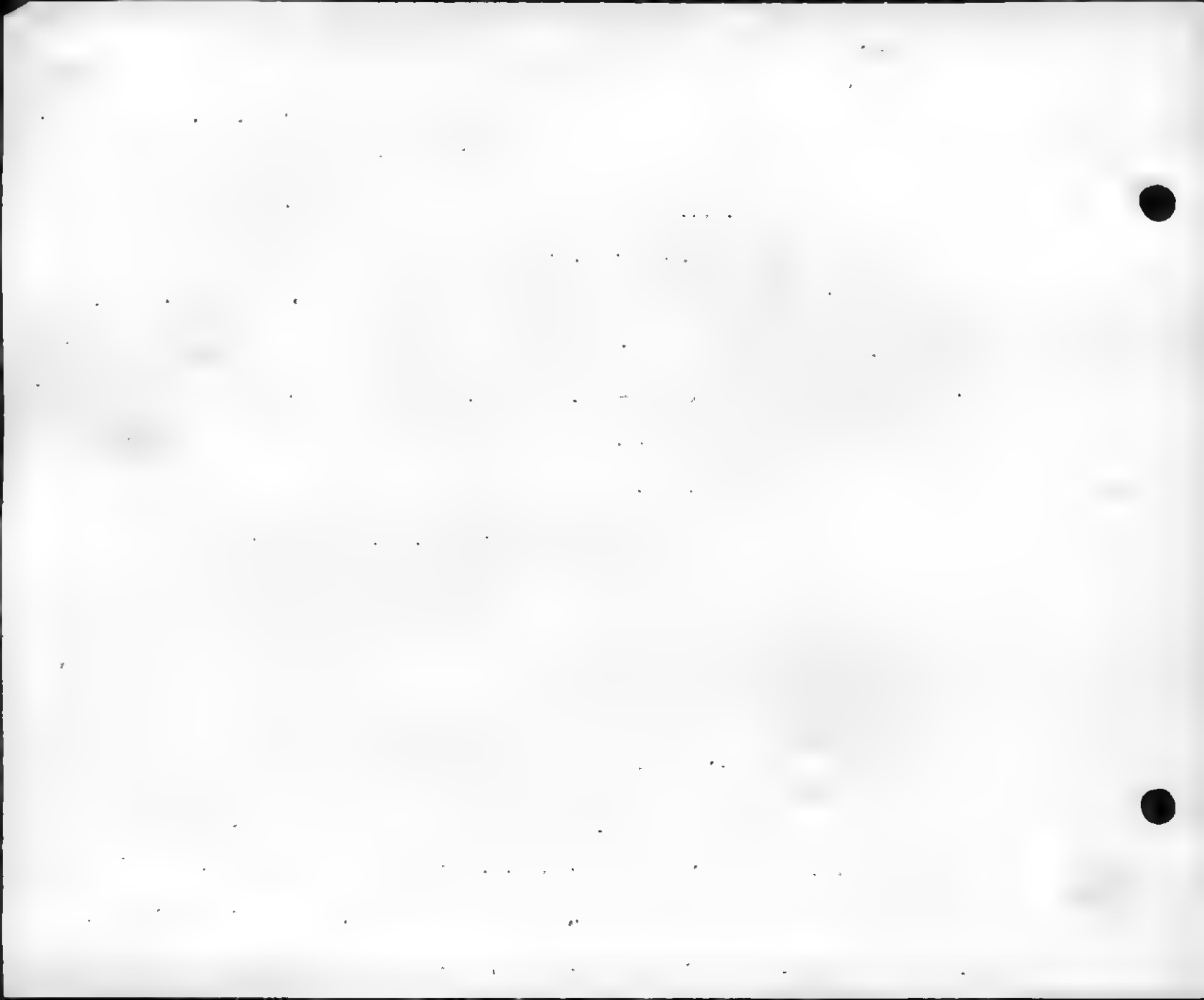
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

05288

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 5:00 AM		
ELLEN				KRUUSMAGI	April 6, 1968				
3 SEX Female	4. RACE White		5 DATE OF BIRTH November 24, 1901		6 AGE (in years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Estonia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b KIND OF BUSINESS OR INDUSTRY		
13a USUA. RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Timonium		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1811 Vista Lane, 21093	
14 FATHER'S NAME First Middle Last Wilhem Kaptein			15 MOTHER'S MAIDEN NAME First Middle Last Leena Kimberg						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO 150-24-3248		17. INFORMANT Address Mrs. Helen Eichhorn 1811 Vista Lane 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Metastasis of pelvic malignancy to lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 19.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from March 23, 1966, to April 6, 1968, that (I) (we) last saw the deceased alive on April 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Dr. Stuart Sunday / Yusup Oh, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>							22c. DATE SIGNED April 6, 1968		
22d. PHYSICIAN'S NAME (Type) Dr. Stuart Sunday / Yusup Oh, M.D.		22e. ADDRESS 7620 York Rd. Towson, Md. 21204							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/10/68		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d LOCATION (City or Town) (County) (State) Lakewood, Ocean Co. N.J.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. Towson, Md.				25a. REC'D BY REGISTRAR -DATE APR 8 - 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be returned by the Hospital or attending physician.

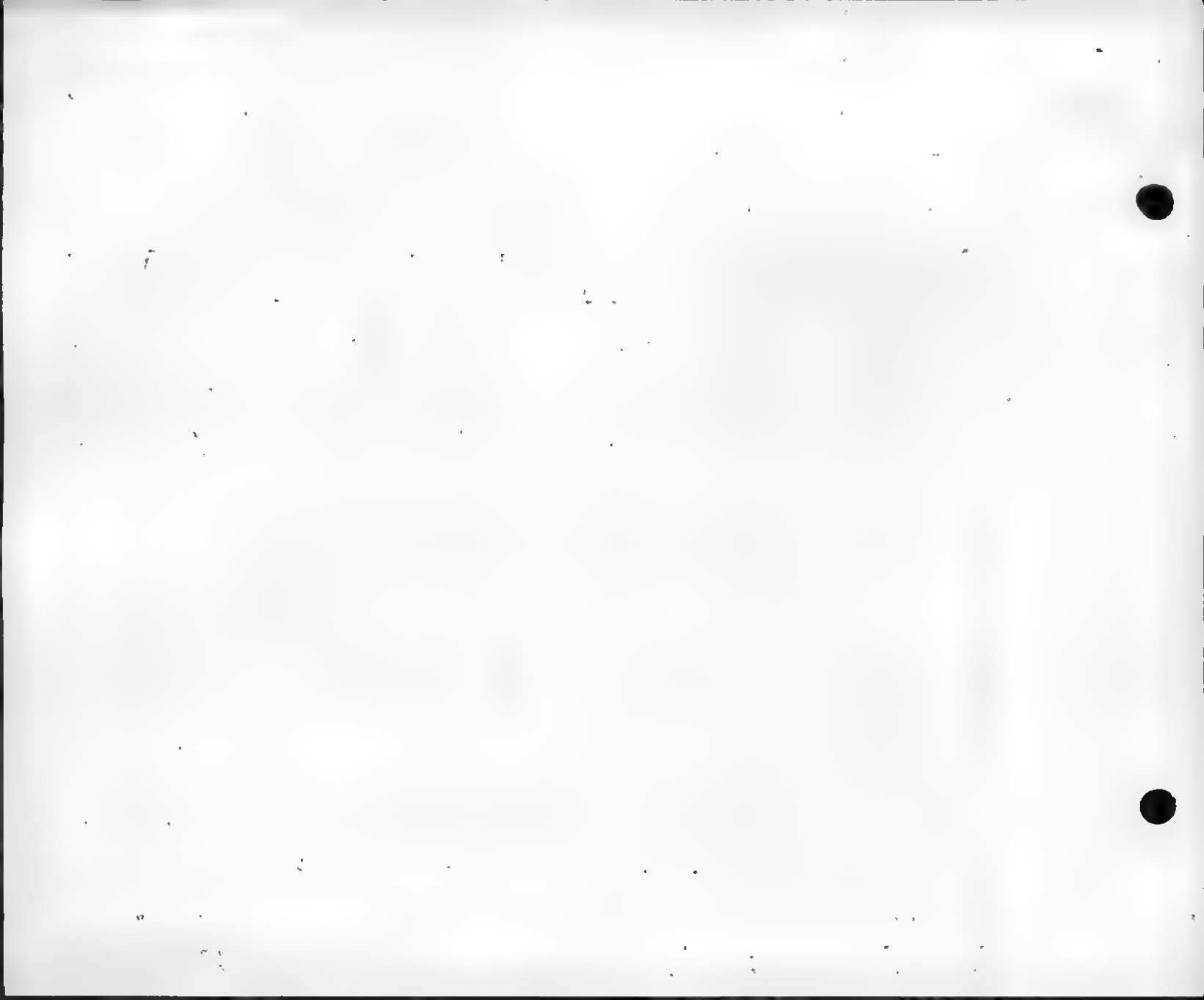
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-64
30M 1-1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EVA			First G. Middle LAND Last			2a. DATE OF DEATH Month APRIL Day 12 Year 1968			2b. HOUR 8:22 AM	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH			6. AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md	
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHANGRI-LA NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First LOUIS Middle GERBER Last			15. MOTHER'S MAIDEN NAME First JENNIE Middle ROSENBLUM Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 212-42-7415	
17. INFORMANT MR. PAUL LAND			Address 8203 MARCIE DRIVE, #8			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized A.S.C.V.D. - CVA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Bronchitis, Asthma			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 4/11 , 19 68 , that (I) (we) lost the deceased alive on 4/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Morton J. Ellin			DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4/12/68			22d. PHYSICIAN'S NAME (Type) MORTON J. ELLIN	
22e. ADDRESS 8629 LIBERTY ROAD			23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-14-68			23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)	
23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.			ADDRESS 6010 REISTERSTOWN ROAD, BALTO. 21215			25a. REC'D BY REGISTRAR DATE APR 16 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge										

MEDICAL CERTIFICATION



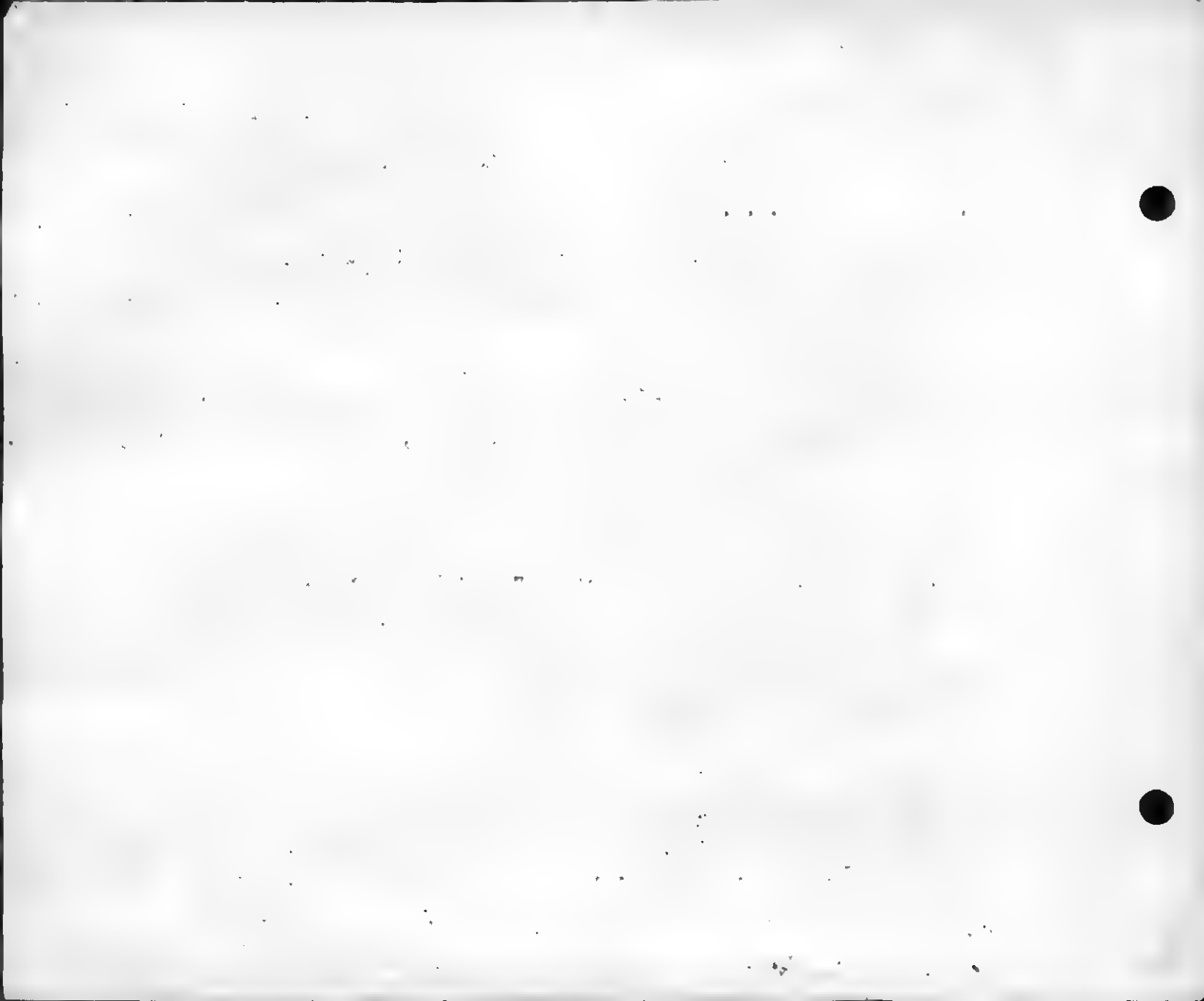
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-15-64
30M REV. 1-1-68

185
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 9:45 PM		
William				Lee	April 25, 1968				
3 SEX Male		4 RACE white		5 DATE OF BIRTH October 1, 1886		6 AGE (In years lost birthday) 81 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County Md.			
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shipping clerk		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY - ✓		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 201 Callow Avenue	
14. FATHER'S NAME Benjamin		15. MOTHER'S MAIDEN NAME Catherine Bond							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 219-54-3208-J1		17 INFORMANT Records: Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal Obstruction, recto-sigmoid area, 2 days. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Cardiovascular Heart Disease.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from March 11, 1956, to April 25, 1968, that (X) (we) last saw the deceased alive on April 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Anthony J. Young, M.D.		22c. DATE SIGNED April 26, 1968		22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22e. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/7/68		23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR E.S. MacNab		25a. REC'D BY REGISTRAR DATE JUN 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



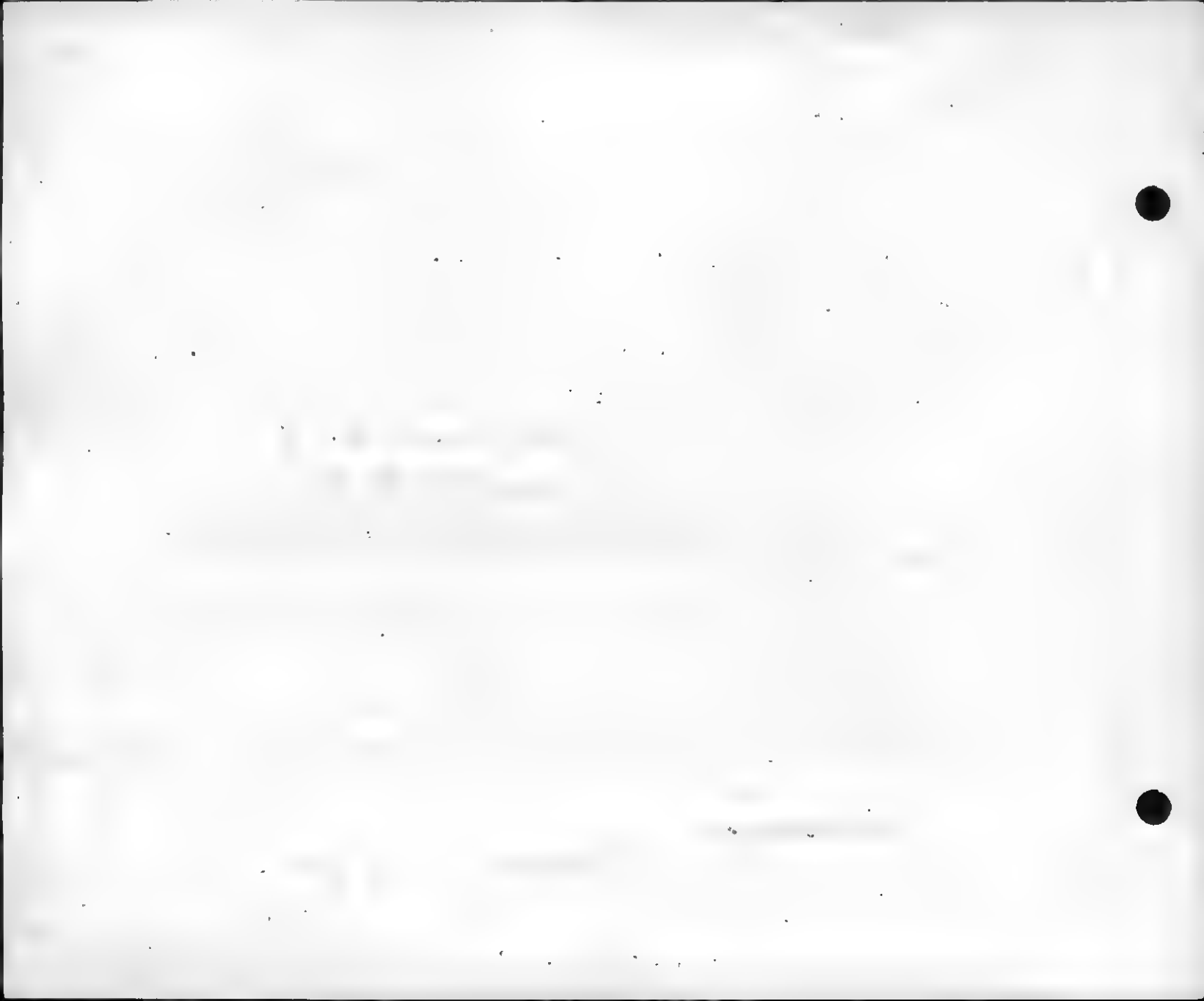
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VR 1515
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Eugene Eugene Leight			First Middle Last			2a. DATE OF DEATH Month Day Year 4 16 68			2b. HOUR 7:45 PM		
3 SEX M		4 RACE W		5 DATE OF BIRTH 8-17-85			6 AGE (In years lost birthday) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Glenn Arm Md.			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTO		
10. CITY OR TOWN OF DEATH BALTO.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO Med. Cen			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 616 Woodbine Ave			13b. COUNTY BALTO			13c. CITY OR TOWN 21204		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME John X Leight			First Middle Last			15. MOTHER'S MAIDEN NAME Owens, Mary E.			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 218-22-1546A			17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Heart Block 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) severe CHF DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 4-15 , 19 68 , to 4-16 , 19 68 , that (I) (we) lost saw the deceased alive on 4-16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE L E L I A C. BALDONADO								DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-16-68	
22d. PHYSICIAN'S NAME (Type) L I L I A C. BALDONADO								22e. ADDRESS G B M C			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4.19.68			23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Md. 21204						ADDRESS		25a. REC'D BY REG STRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATE ON



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

258

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Information taken from birth cert. **CERTIFICATE OF DEATH**

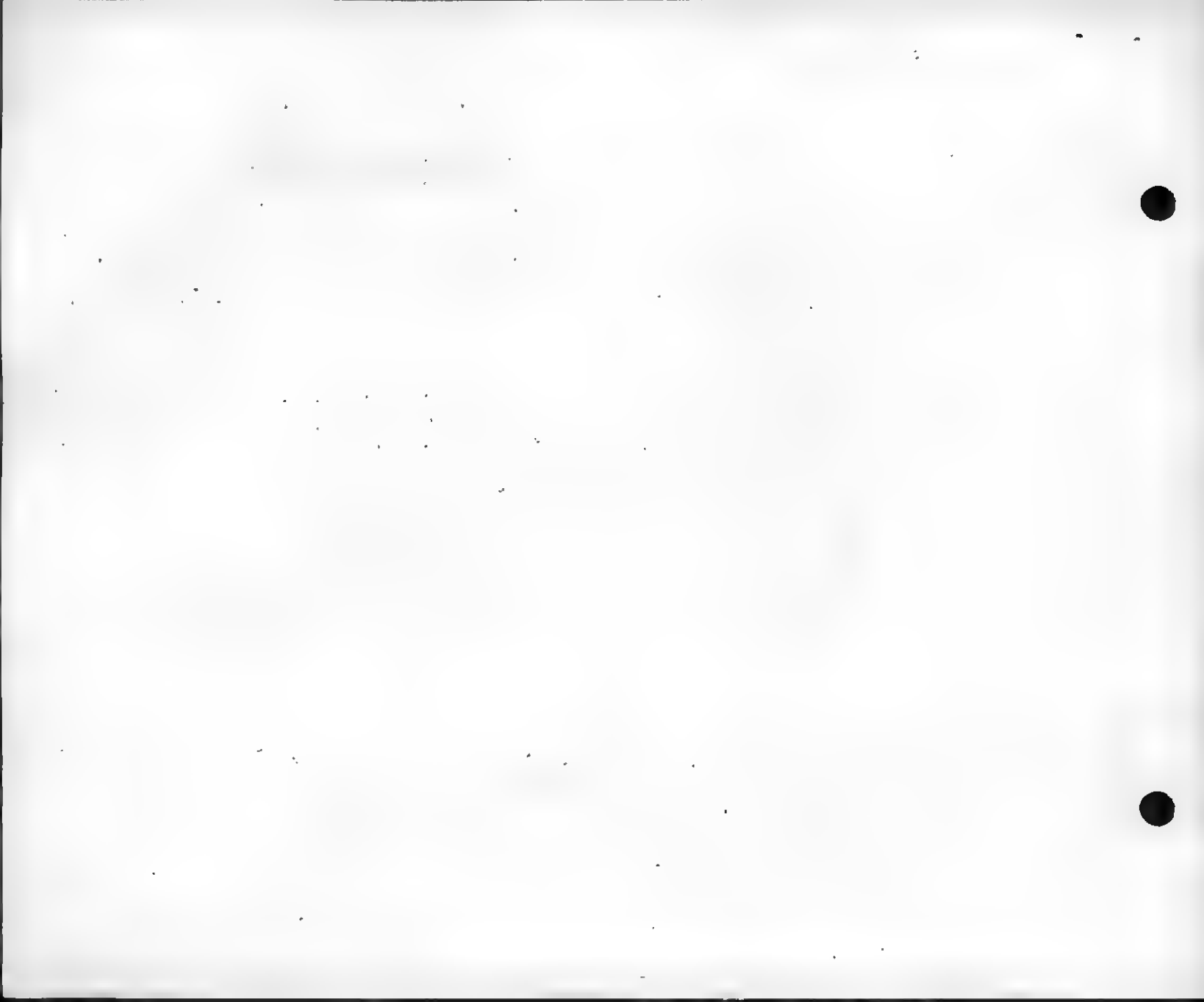
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Larry Keith INFANT					LeMOINE, Jr.	Month 4 Day 22 Year 68			1:25PM	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (n years lost birthday)		IF UNDER 1 YEAR MONTHS 1 DAYS 14		IF UNDER 24 HRS HOURS MIN
Male		Caucasian		March 8, 1968		7. AGE (n years lost birthday)		YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore		USA				Baltimore Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Towson			GREATER BALTO. MED. CENTER							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>		8316 Nunley Drive, Apt. E	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Larry Keith Le Moine			Janice Faye Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
Yes, no, or unknown										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Hypertrophic pyloric stenosis										
7501										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
DUE TO, OR AS A CONSEQUENCE OF										
(b)										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 3/8, 1968, to 4/23, 1968, that (I) (we) lost saw the deceased alive on 4/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE										
John E. Adams										
DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										
22c. DATE SIGNED 4/23/68										
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.										
22e. ADDRESS Greater Baltimore Medical Center										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		4/25/68		G.B.M.C.		Towson, Balto. Md.				
24. FUNERAL DIRECTOR										
John E. Adams, M.D.										
ADDRESS										
G.B.M.C.										
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
DATE		APR 30 1968		John E. Adams						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																					
CERTIFICATE OF DEATH																					
1 DECEASED NAME (Type or print)			First MOSES			Middle LEVIN			Last			2a DATE OF DEATH Month APRIL		Day 25 Year 68		2b HOUR 11:40					
3 SEX MALE			4 RACE WHITE			5. DATE OF BIRTH [REDACTED]			6. AGE (In years last birthday) 36 YRS.			If UNDER 1 YEAR MONTHS 0		If UNDER 24 HRS DAYS 0		HOURS 11		MIN 40			
7a BIRTHPLACE (State or foreign country) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE												
10 CITY OR TOWN OF DEATH PIKESVILLE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STATIONARY			12b. KIND OF BUSINESS OR INDUSTRY RETAIL												
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 8402 MERRYMOUNT DR.									
14. FATHER'S NAME First JACOB			Middle ?			Last ?			15. MOTHER'S MAIDEN NAME First SARAH			Middle ?			Last ?						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-32-7728			17 INFORMANT MRS. JENNIE SPJUT			Address 8402 MERRYMOUNT DR.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease												10 years									
4129 DUE TO, OR AS A CONSEQUENCE OF- (b) Carcinoma of prostate												9 years									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ?																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None																					
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from Sept 27, 1962 to April 25, 1968 , that (I) (we) last saw the deceased alive on April 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Manuel Levin			DEGREE MANUEL LEVIN			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4/25/68												
22d. PHYSICIAN'S NAME (Type) MANUEL LEVIN			22e ADDRESS 6101 PARK HEIGHTS AVE MD																		
23a B. RIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-28-68			23c NAME OF CEMETERY OR CREMATORY WORKMENS CIRCLE			23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND												
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.			ADDRESS 6010 REISTERSTOWN ROAD, BALTO. 21215			25a. RECEIVED BY REG. STRAR APR 30 1968			25b. REGISTRAR'S SIGNATURE Charles Judge												

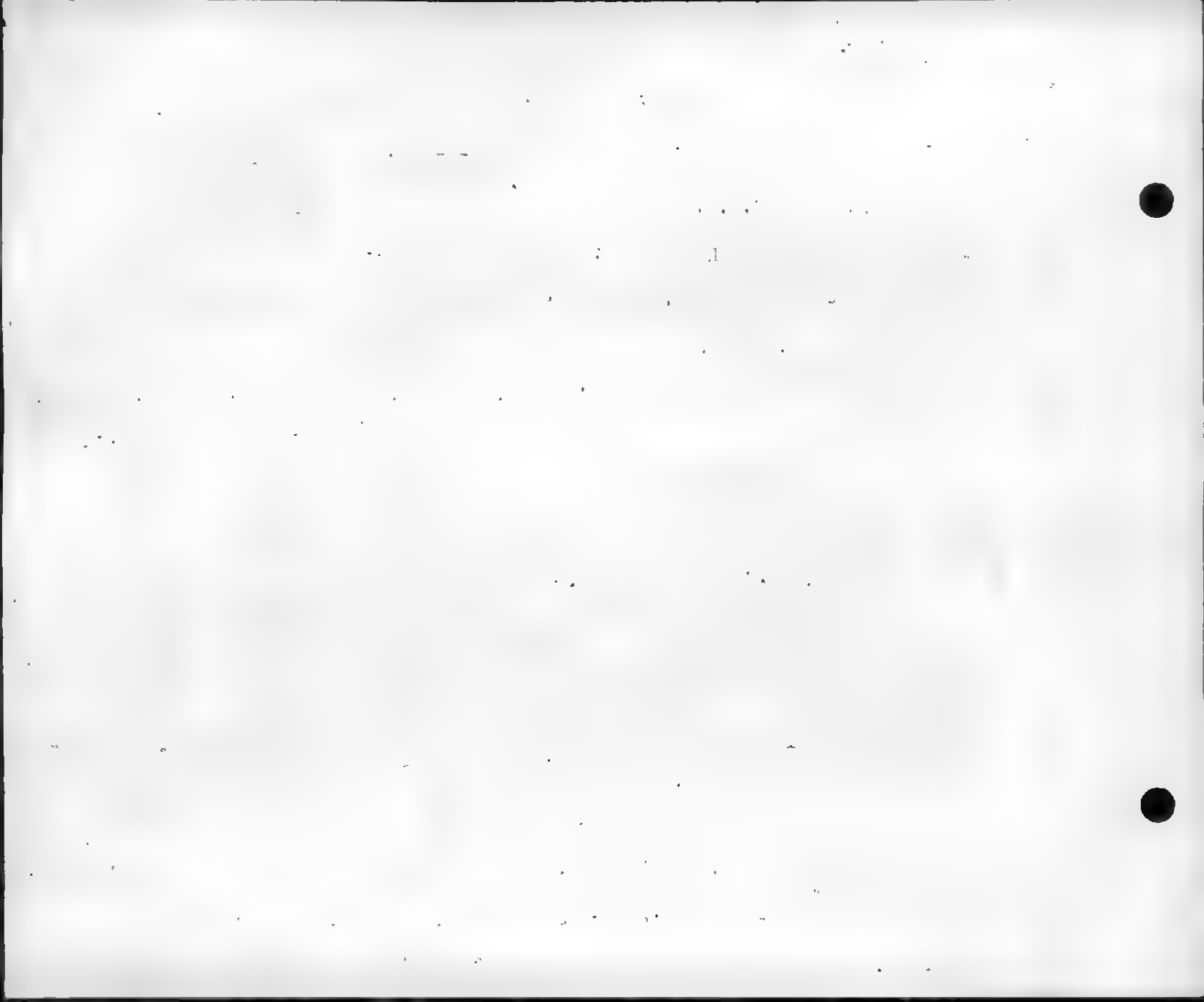


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (A)
30M REV. 1/68

MIDDLE									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
CHARLES MARSHALL LEWIS						April Month 16, Day 1968		1:57 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (n years last birthday)		IF UNDER 1 YEAR	
Male		White		10-1-1885		82 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Virginia		U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		House in the Pines		Retired					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Arbutus		YES <input type="checkbox"/> NO <input type="checkbox"/>		930 Leeds Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William M. Lewis			Susanna Carr						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
(If yes give war or dates of service)		577-12-7218		Mrs. Flora S. Lewis		930 Leeds Avenue 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:								7 yrs.	
IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Arteriosclerotic cardiovascular disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1953, to April 16, 1968, that (I) (we) last saw the deceased alive on April 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John A. Nesbitt, Jr.</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-17-68	
22d. PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt, Jr.						22e. ADDRESS 1009 Frederick Road, Catonsville, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4-19-1968		Loudon Park Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard, 4107 Wilkens Ave. 21229				DATE APR 18 1968		<u>Charles Judge</u>			



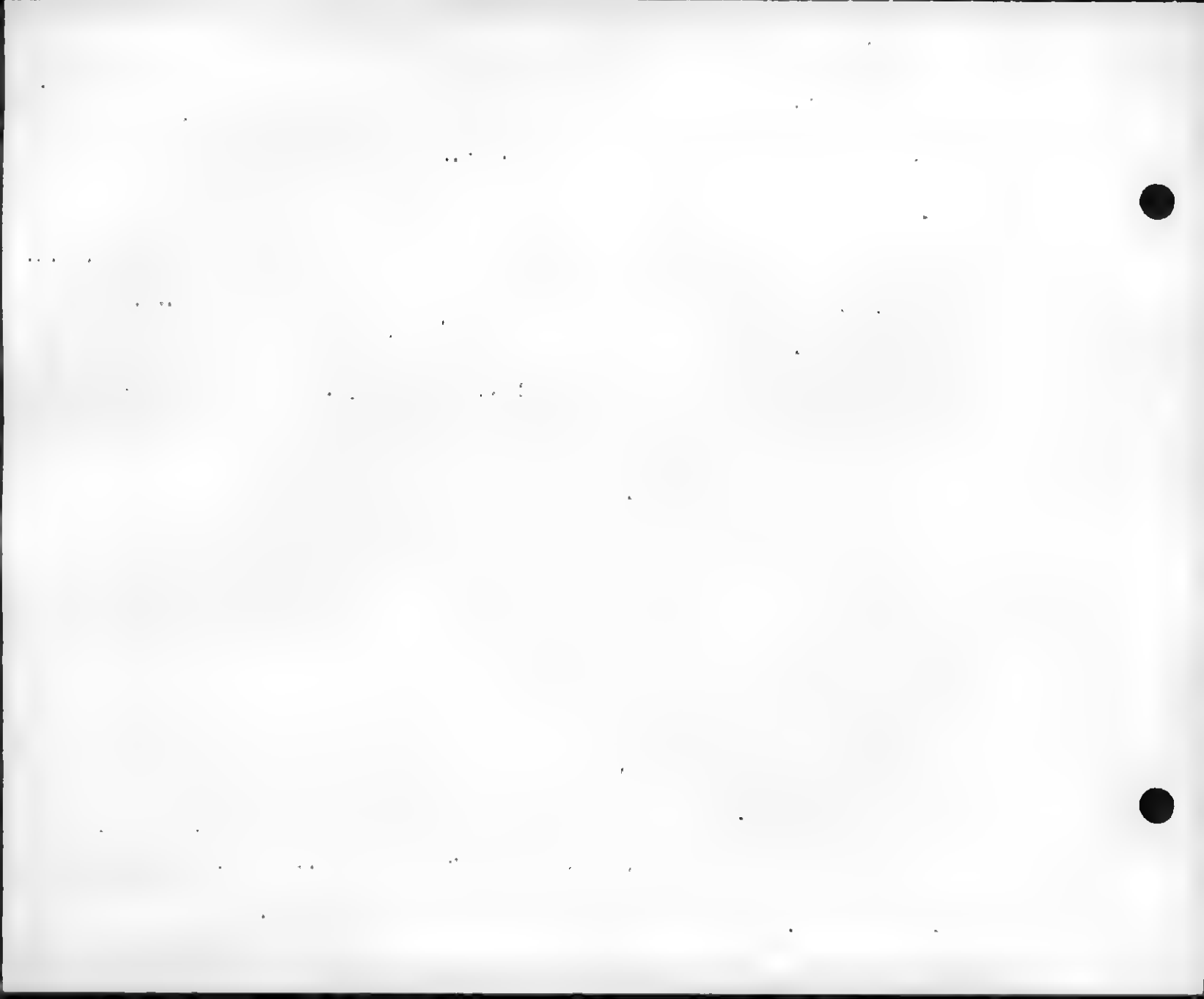
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VR A15 (4)
30M REV 1/68

MAY 2 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) MERRILL		First Middle Last LEWIS		2a. DATE OF DEATH Month Day Year April 26, 1968		2b. HOUR AM PM 12:10 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH December 14, 1898		6. AGE (In years lost birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) retired		12b. KIND OF BUSINESS OR INDUSTRY Penna. R.R.	
13a. USUAL RES DENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 420 Maryland Ave. 21221	
14. FATHER'S NAME First Middle Last WILLIAM LEWIS				15. MOTHER'S MAIDEN NAME First Middle Last ADA REED			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown UNK		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT BEATRICE LEWIS		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 18, 1968 , to April 26 19 68 , that (I) (we) last saw the deceased alive on April 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Eduardo Montelibano</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED April 26, 1968	
22d. PHYSICIAN'S NAME (Type) Eduardo Montelibano, M.D.				22e. ADDRESS 7620 York Rd.. Towson, Maryland 21204			
23a. BURIAL, CREMATON, REMOVAL BURIAL		23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR <i>J. A. Connelly</i>				ADDRESS 300 more		25a. REC'D BY REGISTRAR <input checked="" type="checkbox"/> DATE APR 30 1968	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>							



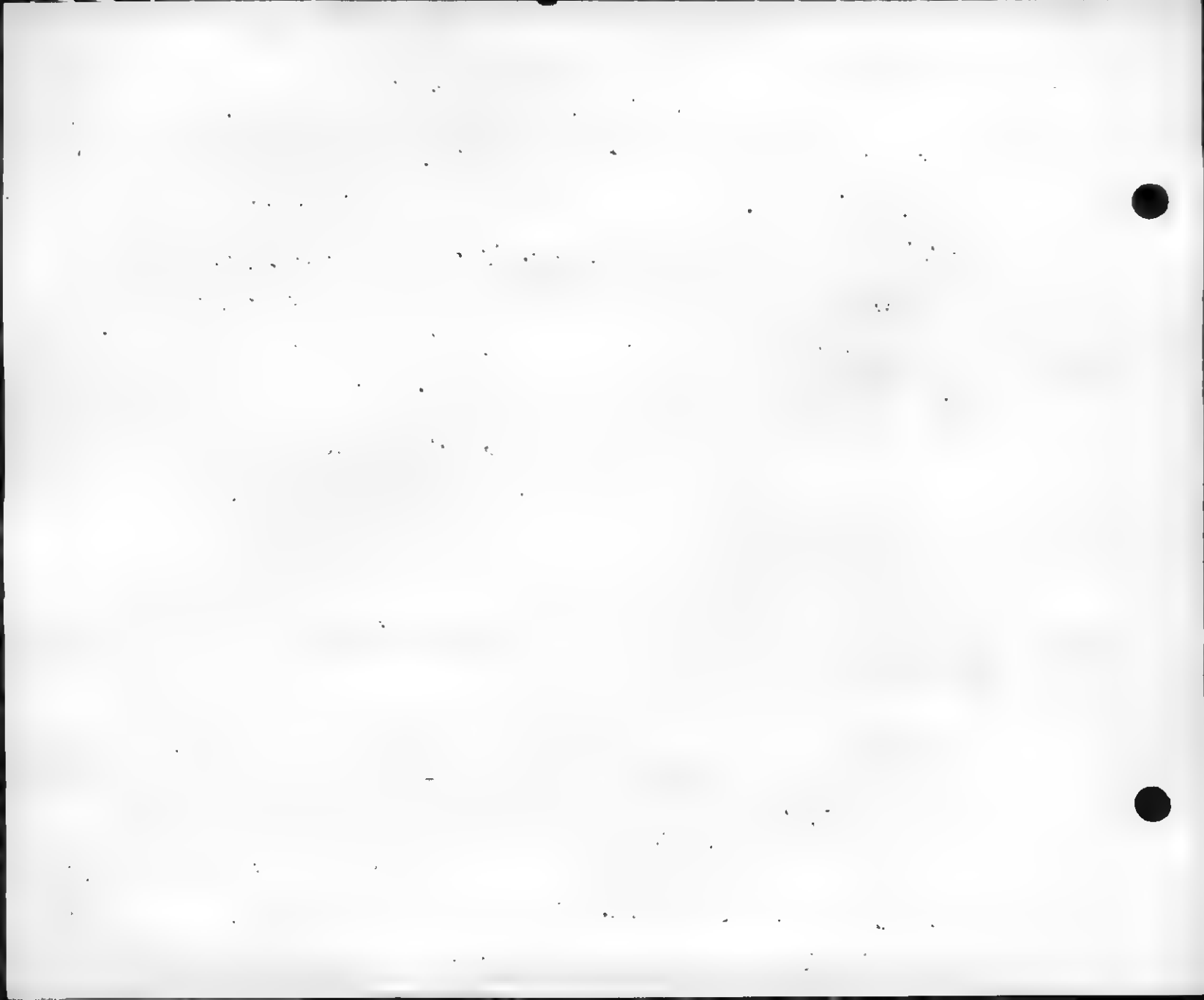
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) HELEN BONITA Libby		First Middle Last (LINDBERG)		2a DATE OF DEATH Month 4 Day 24 Year 68		2b. HOUR 7:27 PM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH 9/25/10		6 AGE (In years lost birthday) 57 YRS.	
7a BIRTHPLACE (State or foreign country) FLORIDA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO Md.	
10 CITY OR TOWN OF DEATH BALTO		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto Med Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13e. STREET AND NUMBER 920 BARON AVE 31221	
14 FATHER'S NAME First Jerome Middle Capo Last Capo		15. MOTHER'S MAIDEN NAME First UNKNOWN Middle FANNIE Last ?					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOC AL SECURITY NO. UNKNOWN		17. INFORMANT Pt's Chart Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) pneumal effusion 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Ca. lung with liver metastases DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 11							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 4-16 , 19 68 , to 4-24 , 19 68 , that (I) (we) last saw the deceased alive on 4-24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE E.R. Soudijn		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-24			
22d PHYSICIAN'S NAME (Type) E.R. Soudijn		22e ADDRESS GREATER BALTO. MED. CENTRE					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 4/27/68		23c NAME OF CEMETERY OR CREMATORY Oak Lawn		23d LOCATION (City or Town) (County) (State) BALTO. Md.	
24. FUNERAL DIRECTOR Connelly Funeral Home		ADDRESS 300 Mac Ave		25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH			
1 DECEASED NAME (Type or print) First Middle Last Blanche M. Lingg				2a DATE OF DEATH Month Day Year April 11 1968			
3 SEX Female		4 RACE Cau.		5 DATE OF BIRTH May 10, 1894		6 AGE (in years lost birthday) 73 YRS.	
7a BIRTHPLACE (State or foreign country) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Pikesville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 19 Old Court Rd. Presser		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Uniform	
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3317 Hayward Ave.	
14 FATHER'S NAME First Middle Last Richard Whitcomb				15 MOTHER'S MAIDEN NAME First Middle Last Ruth Fuller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 216-01-1798		17 INFORMANT Address Mr. James H. Lingg, 3317 Hayward Ave. Balto. Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1958							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1958 , to Apr. 11, 1968 , that (I) (we) lost saw the deceased alive on April 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Donald Jandorf DEGREE R. Donald Jandorf, M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-11-68	
22d. PHYSICIAN'S NAME (Type) R. Donald Jandorf, M.D.				22e. ADDRESS 6077 Harford Road, Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/1968		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co. Md.	
24. FUNERAL DIRECTOR 6. Vernon Lemmon ADDRESS 4611 Park Heights Ave. Balto.				25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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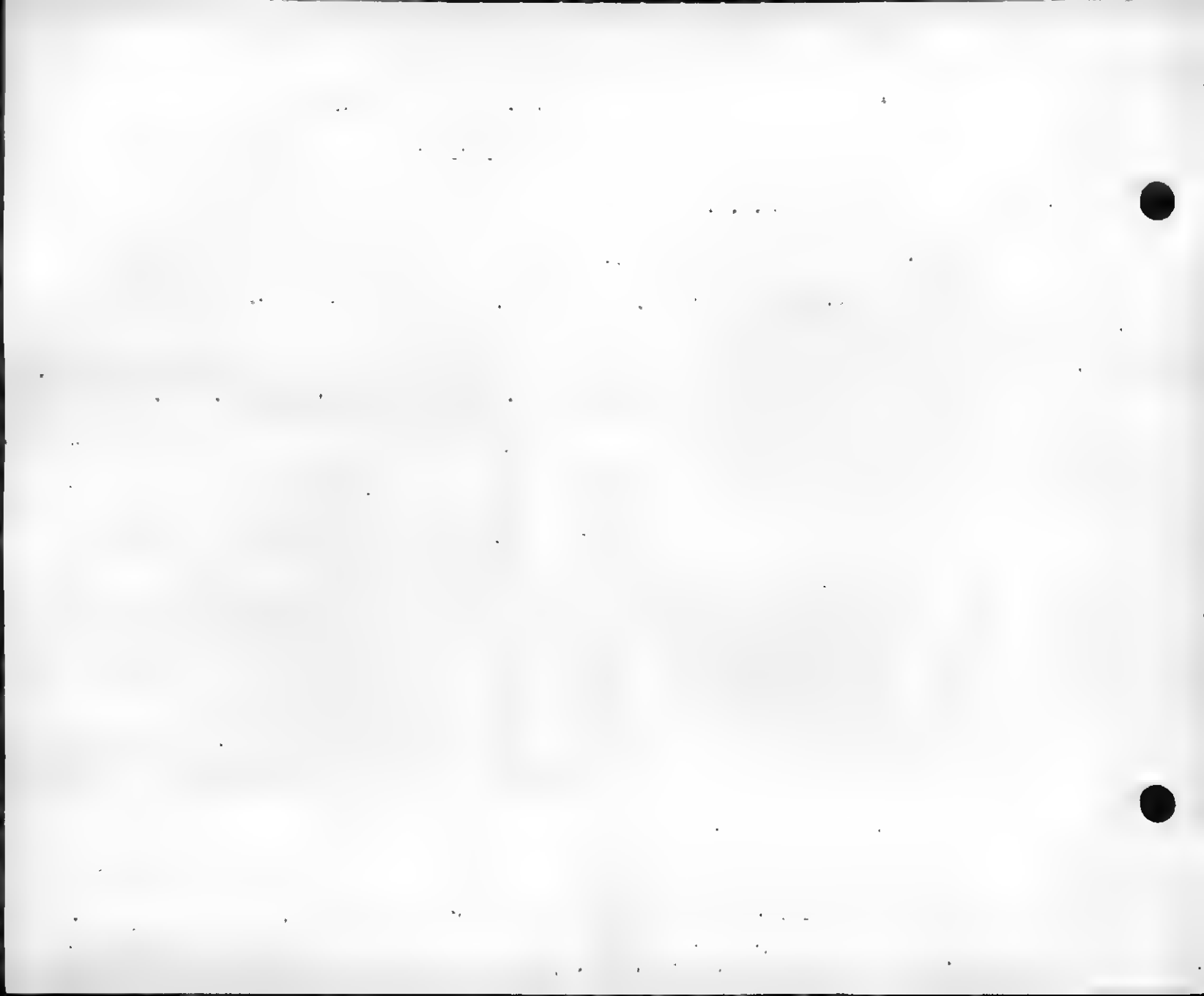
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Rose			First Lombardo			Last			2a. DATE OF DEATH 4-29-68 Month Day Year			2b. HOUR M			
3. SEX Female			4. RACE W			5. DATE OF BIRTH 11-21-1886			6. AGE (in years last birthday) 81 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			Md			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangri-La Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Balto.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4903 St. Gemma Road			
14. FATHER'S NAME Joseph Dantoni			First Middle Last			15. MOTHER'S MAIDEN NAME Lucy Poligardo			First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Vincent Lombardo, Balto., Md. 21207			1540 Forest Park Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic CVD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes Mellitus												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months			
												3 months			
												10 years			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 66 , to April 29 , 19 68 , that (I) (we) last saw the deceased alive on April 23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Kennard Yaffe MD			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/30/68						
22d. PHYSICIAN'S NAME (Type) KENNARD YAFFE			22e. ADDRESS 5501 Forest Park Ave												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5-2-68			23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Balto. Md.						
24. FUNERAL DIRECTOR Witzke Funeral Directors, Balto., Md. 21229			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 1 1968			25b. REGISTRAR'S SIGNATURE Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print) JOHN OLIVER LONG						2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 4-21-68			2b HOUR 10:00			
3 SEX Male		4 RACE White		5 DATE OF BIRTH July 11, 1894		6 AGE (In years last birthday) 73 YRS		7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		8 IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore			2c DATE PRONOUNCED DEAD Month April Day 22 Year 1968			
10 CITY OR TOWN OF DEATH Dundalk			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2902 Liberty Parkway			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY Balto. City Health Dept.			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2902 Liberty Parkway			
14 FATHER'S NAME First ? Middle ? Last ?						15 MOTHER'S MAIDEN NAME First ? Middle ? Last ?						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b SOCIAL SECURITY NO W.W.I. 215-16-9698A		17 INFORMANT Alfred Long			ADDRESS 8504 Kavanaugh Rd., 21222			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V Disease 4129 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) ? DUE TO, OR AS A CONSEQUENCE OF (c) ? DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 11.2												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Melvin B. Davis						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4/23/68			
EXAMINER'S NAME (Type) Melvin B. Davis, M. D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county) 6800 Morningside Rd. 21222			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4/25/68		23c NAME OF CEMETERY OR CREMATORY Moreland Mem. Park				23d LOCATION (City or Town) Baltimore		(County) (State) Md.		
24 FUNERAL DIRECTOR Thelma A. Hoffman						ADDRESS 3218 Hudson Street			25a REC'D BY REG. STRAR APN 26 1968		25b REG. STRAR'S SIGNATURE J. Charles Judge	



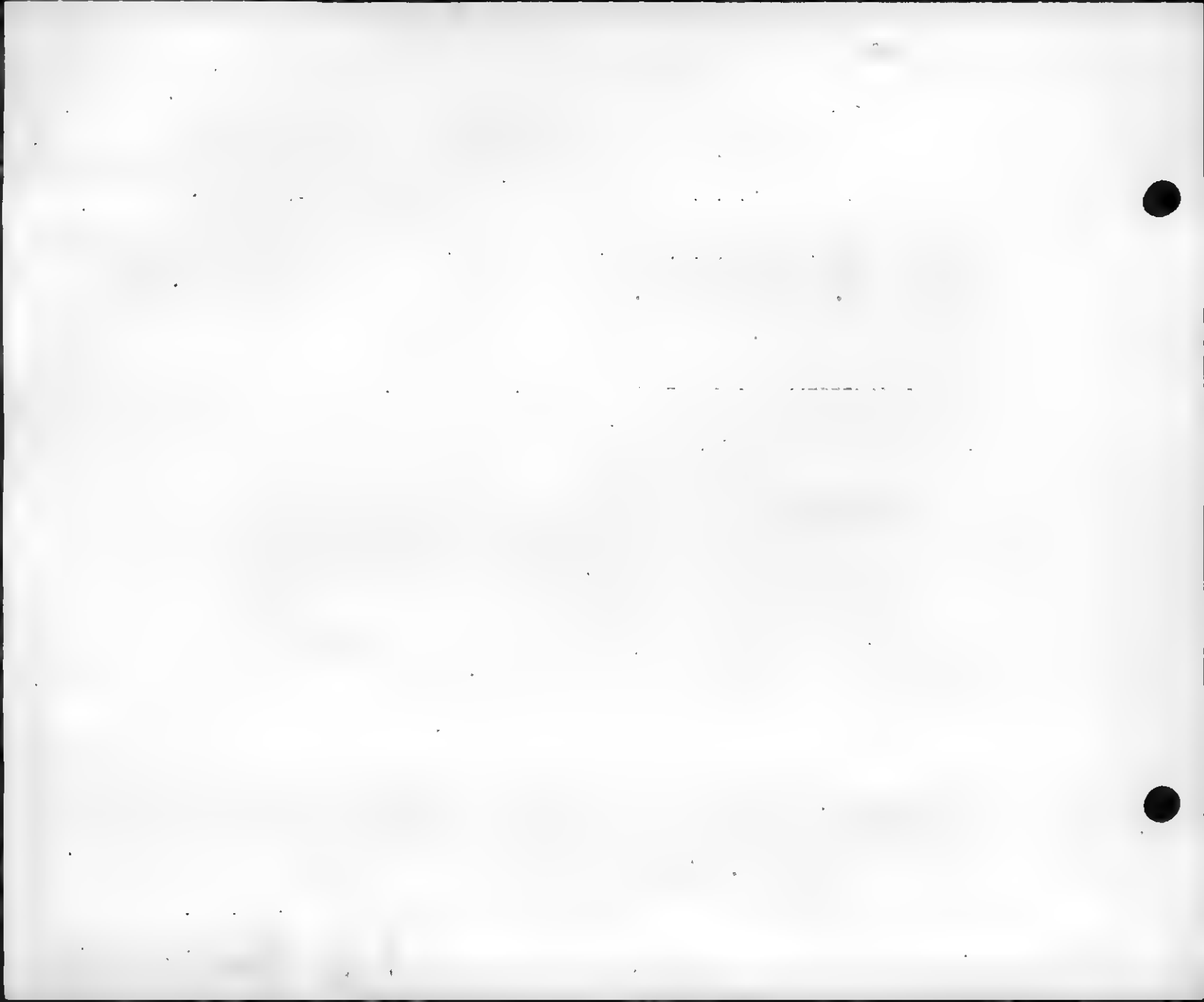
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form CMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Grace Alice Lonsdale			2a DATE KNOWN OF DEATH MAY 18 1968		2b HOUR 8 PM	
3 SEX F	4 RACE W	5 DATE OF BIRTH 11/4/32	6 AGE (In years last birthday) 35 YRS	7 UNDER YEAR MONTHS 1	8 UNDER 24 HRS HOURS 1	9 COUNTY OF DEATH Baltimore Md
7a BIRTHPLACE (State or foreign country) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md
10 CITY OR TOWN OF DEATH Balto. County		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D.O.A. St. Joseph Hosp.		12a USUAL OCCUPATION (Kind of work done during major work life even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Lutherville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First Willard Middle L. Last Bennett			15. MOTHER'S MAIDEN NAME First Eudora Middle Lewis			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO. (If yes give war or dates of service) 212-28-3667		17. INFORMANT ADDRESS Mr. Richard T. Lonsdale, Same as # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture of Neck and Severance of Spinal Cord at Brain Stem DUE TO, OR AS A CONSEQUENCE OF (b) Sudden DUE TO, OR AS A CONSEQUENCE OF (c) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year April 22 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Car Ran off Road Struck a Tree		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or RFD No. City or Town County State Lutherville Pike 1300 FT North Blenheim		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Sunnyside						
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4/22/68	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS (Street, city, town, or county) Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204						
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE 4-25-1968		23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d LOCATION (City or Town) (County) (State) Pikesville, Md.
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a RECD BY REGISTRAR APR 25 1968		25b REGISTRAR'S SIGNATURE Charles F. O'Donnell



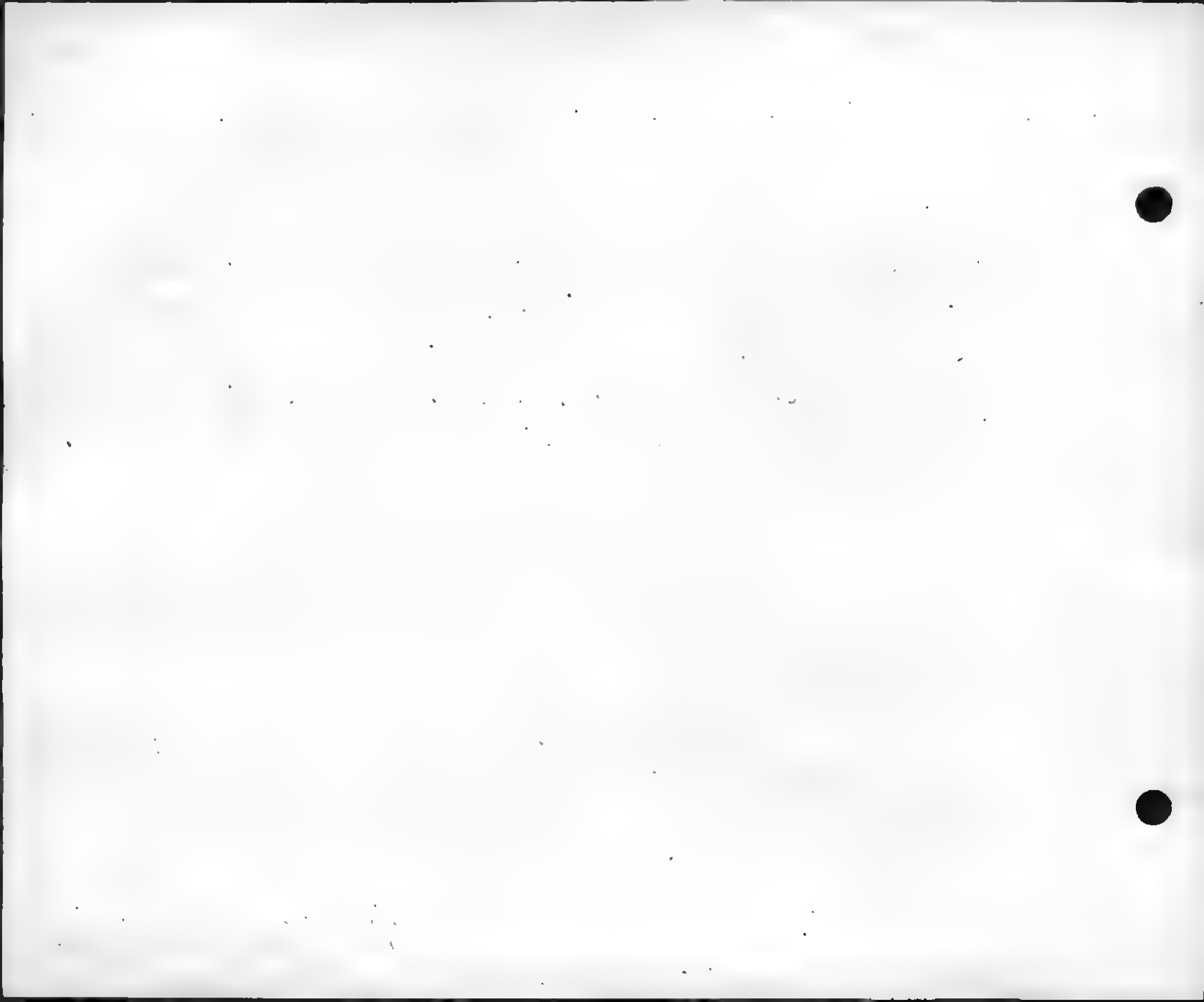
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-19-71
30M REV. 1/68

MD 298
MAY 29 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

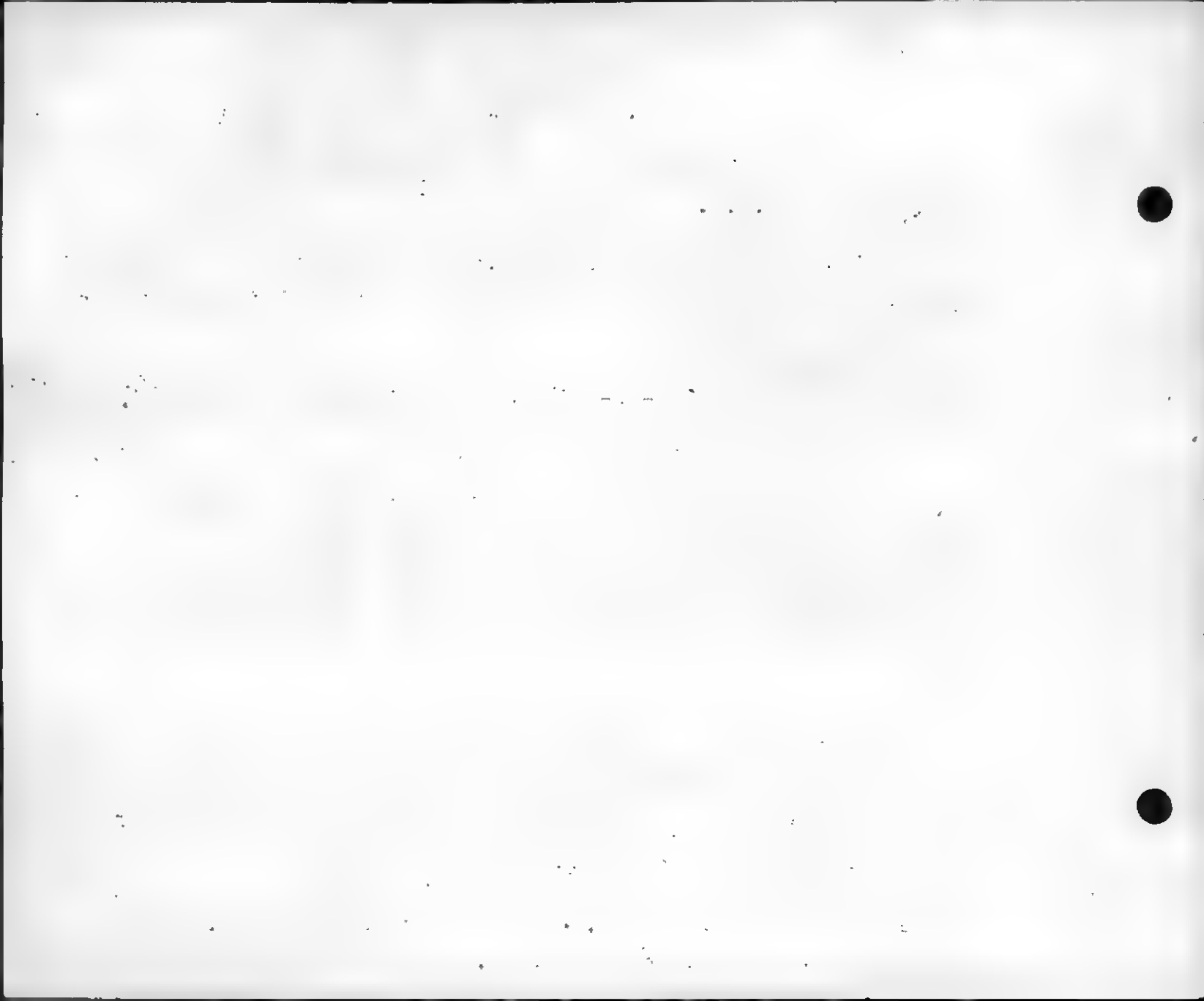
1. DECEASED-NAME (Type or print) George E. Mack		First Middle Last		2a. DATE OF DEATH Month Day Year April 16, 1968		2b. HOUR 6:30 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 30, 1894		6. AGE (In years lost b rthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Halethorpe		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5723 First Ave		12a. USJA. OCCUPATION (Kind of work done during most of work ng life, even if retired) Crain Operator		12b. KIND OF BUSINESS OR INDUSTRY Western Electric	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Halethorpe		13d. STREET AND NUMBER 5723 First Ave	
14. FATHER'S NAME Gustav Mack		First Middle Last		15. MOTHER'S MAIDEN NAME Mary Schwarz		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 215-10-4196		17. INFORMANT Agnes A. Mack		Address 5723 First Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1541							
19a. DATE OF OPERATION 4-20-66		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of rectum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Apr. 20, 1966, to Apr. 16, 1968, that (I) (we) last saw the deceased alive on Apr. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Bradley Daugharty MD				22c. DATE SIGNED 4-16-68		22e. ADDRESS 1264 Francis Ave	
22d. PHYSICIAN'S NAME (Type) Dr. A. Bradley Daugharty				22e. ADDRESS 1264 Francis Ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/68		23c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Ambrose, Inc. 1328 Sulphur Spring Rd				25a. RECEIVED BY REGISTRAR APR 19 1968		25b. REGISTRAR'S SIGNATURE John Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
James E. Mack						Month Day Year April 8 68			8 a.m.				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Male		Negro		1893			75 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland			U.S.A.						Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Reisterstown			Bent Nursing Home			Laborer			Unknown				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Baltimore			Glyndon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			85 Railroad Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Unknown			Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
Unknown			219-16-5601			Bent Nursing Home Records			Reisterstown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u>												24-48 hrs.	
DUE TO, OR AS A CONSEQUENCE OF													
(b) <u>Malnutrition, Epilepsy, Arteriosclerosis (H.D.)</u>												years	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c))													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (H) (this hospital) attended the deceased from <u>2/13</u> , 19 <u>67</u> , to <u>4/8</u> , 19 <u>68</u> , that (H) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED										
Martin E. Strobel, MD			2/8/68										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
MARTIN E. STROBEL			REISTERSTOWN MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			April 10, 1968			Mt. Auburn Cemetery Baltimore, Maryland							
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
H. J. Edhardt			Owings Mills, Md.			DATE APR 10 1968			Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
304a REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) James Simon MacKenzie			2a. DATE OF DEATH Month April Day 24 Year 1968		2b. HOUR M
3 SEX Male	4 RACE White	5 DATE OF BIRTH Jan. 10, 1903		6 AGE (In years lost birthday) 65 YRS	7 FINDER 1 YEAR MONTHS 1 DAYS 1 HOURS 1 MIN 1
7a BIRTHPLACE (State or foreign country) Scotland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Nursing	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor	12b KIND OF BUSINESS OR INDUSTRY Lever Bros.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN Timonium	3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 2413 Springlake Dr. 21093	
14. FATHER'S NAME First Middle Last John L. MacKenzie		15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Cormie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO 012-10-7379	17 INFORMANT Address Mrs. Helen U. MacKenzie 2413 Springlake Dr.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral hydrocephalus DUE TO, OR AS A CONSEQUENCE OF (c) Rupture arteriovenous aneurysm					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 3 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 330x					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from August 24, 1965 , to April 24, 1968 , that (I) (we) last saw the deceased alive on April 20 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Donald O Wood M DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/>				22c DATE SIGNED 4-26-68	
22d PHYSICIAN'S NAME (Type) DONALD O. WOOD, M.D.				22e ADDRESS York Road and Greenmeadow Drive Timonium, Maryland 21093	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4/27/68	23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Balto. Md.	
24 FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204				25a RECD BY REGISTRAR DATE Apr 29 1968	
				25b REGISTRAR'S SIGNATURE James J. Judge	



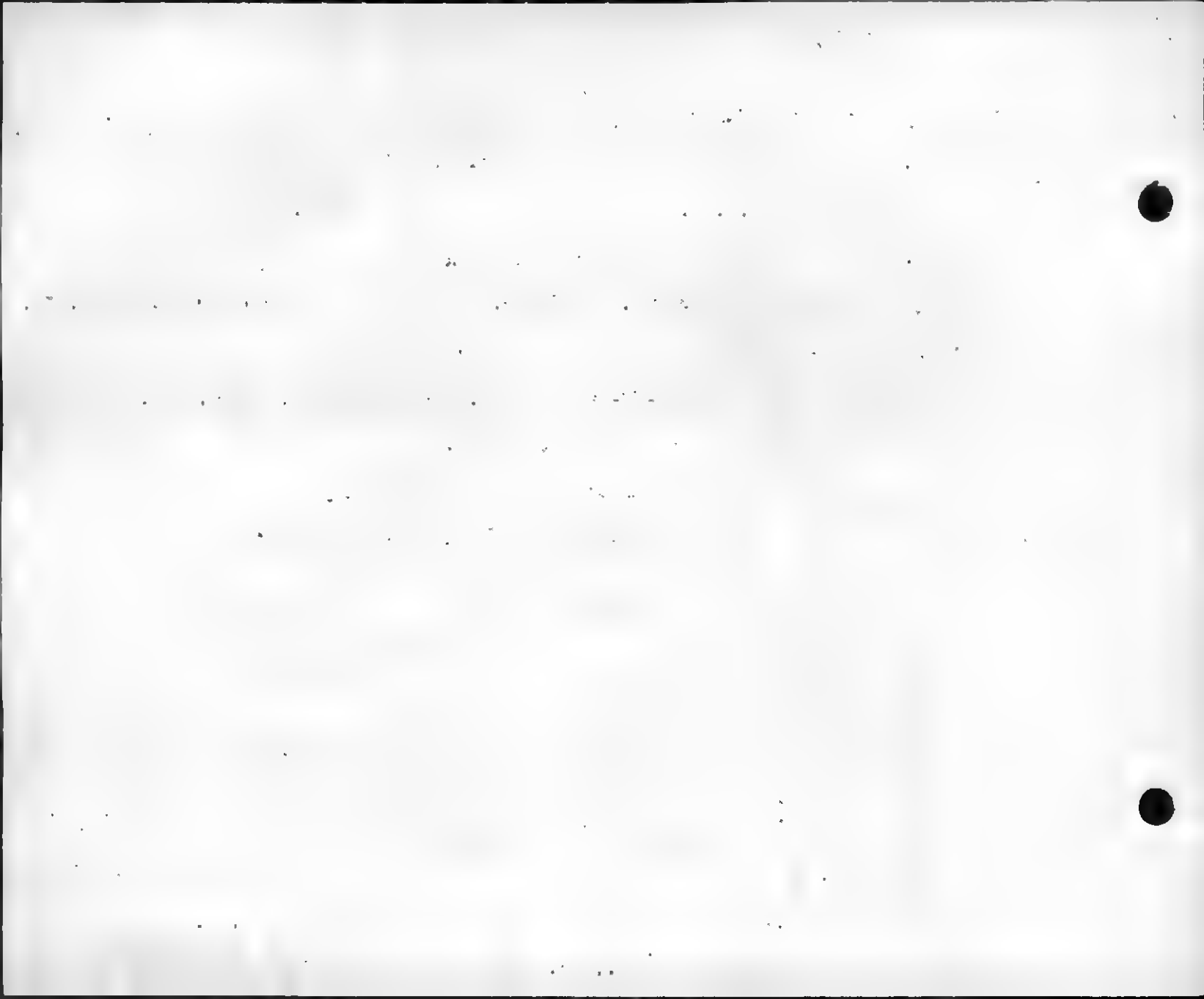
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MD 2009
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Frank Macneill			2a. DATE OF DEATH Month Day Year APR 23 1968			2b. HOUR 7:55 PM				
3 SEX Male		4 RACE W		5. DATE OF BIRTH Aug. 5, 1895		6. AGE (In years last birthday) 72 YRS		7. UNDER YEAR MONTHS DAYS 11 MONTHS 11 DAYS 11 HOURS 11 MIN.		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md.				
10. CITY OR TOWN OF DEATH Balto.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. USUAL CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 704 Cooks Lane, Balto., Md.	
14. FATHER'S NAME First Middle Last Frank Macneill			15. MOTHER'S MAIDEN NAME First Middle Last Mary Bell Macneill							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 081-09-8018-A		17. INFORMANT 704 Cooks Lane Address Mrs. Frank Macneill, Balto., Md. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Larynx DUE TO, OR AS A CONSEQUENCE OF (c) Virus-like Cancerous Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1968 , to Apr 23, 1968 , that (I) (we) last saw the deceased alive on Apr 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE HARRY Knipp MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 4-24-68				
22d. PHYSICIAN'S NAME (Type) Dr. HARRY Knipp						22e. ADDRESS 4116 Edmondson Ave 21229				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-27-68			23c. NAME OF CEMETERY OR CREMATORY Laurel Memorial Park			23d. LOCATION (City or Town) (County) (State) Pomona, N. J.	
24. FUNERAL DIRECTOR Witzke Funeral Directors, Balto., Md. 21229						25a. REC'D BY REGISTRAR APR 25 1968		25b. REGISTRAR'S SIGNATURE J. J. Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

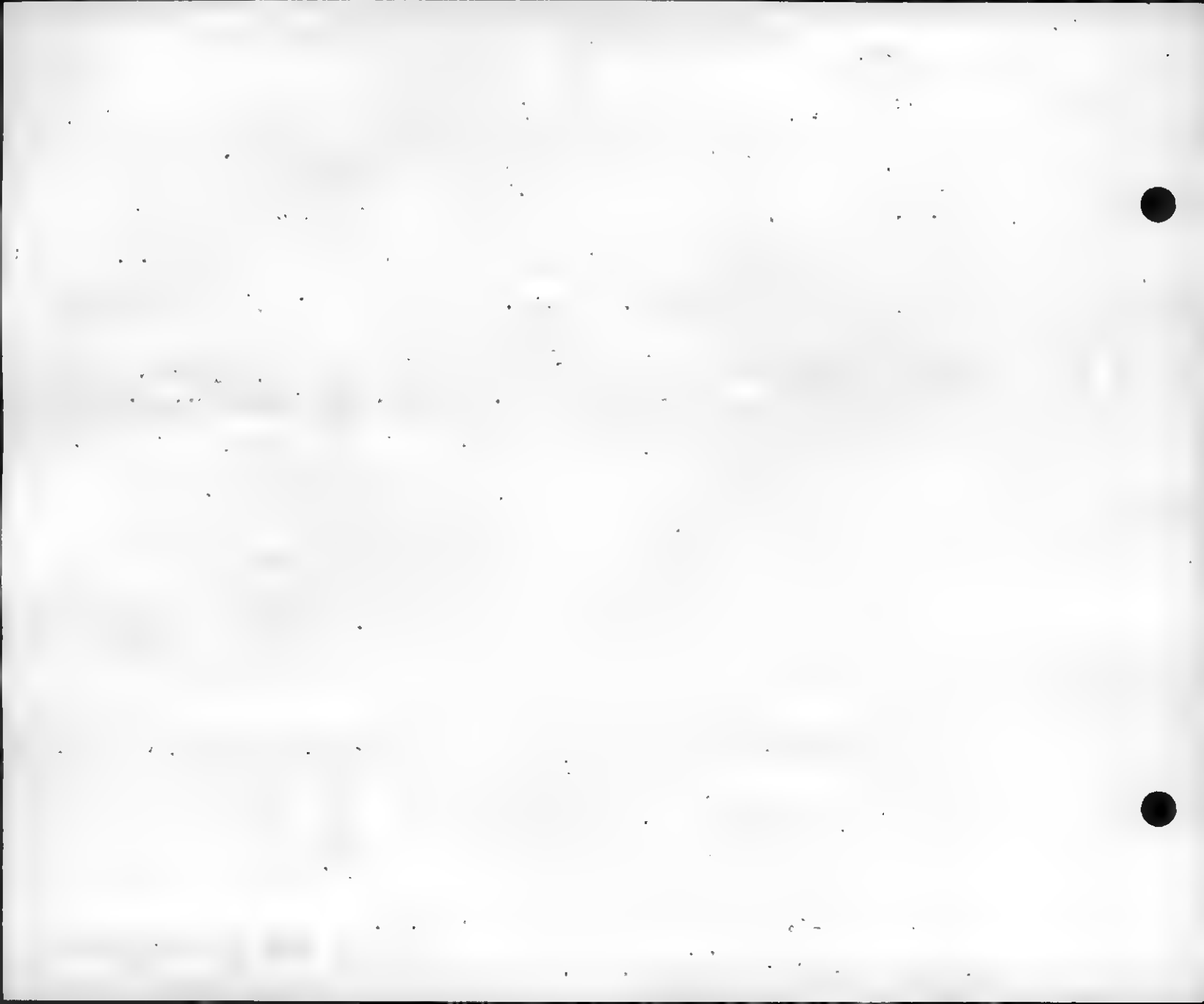


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 100
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>George W. Malkemus</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>15</i> Year <i>1968</i>			2b. HOUR <i>8:07 PM</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Sept. 4th 1889</i>		6 AGE (In years lost birthday) <i>78</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>N. Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>America</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore County, Md.</i>	
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Rubber Co.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>15 Mallow Hill Rd.</i>		14. FATHER'S NAME First Middle Last <i>Andrew Malkemus</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>MARY</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>216-01-2702</i>		17 INFORMANT <i>Mrs. George W. Malkemus</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>342X Intestinal Obstruction - recurrent</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Parkinson's disease - intestinal</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>atony + cardiac arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>34 hrs.</i> <i>3 yrs.</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>342X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>April 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 15, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Harry B. Scott M.D.</i>		22c. DATE SIGNED <i>4/15/68</i>		22d. PHYSICIAN'S NAME (Type) <i>HARRY B SCOTT M.D.</i>			
22e. ADDRESS <i>721 Medical Arts Bldg.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-18-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rural (Poughkeepsie, N. Y.)</i>		23d. LOCATION (City or Town) (County) (State) <i>(County) (State)</i>	
24. FUNERAL DIRECTOR <i>4101 Edmondson Avenue</i> <i>Witzke Funeral Directors, Balto., Md. 21229</i>		25a. REC'D BY REGISTRAR <i>APR 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>			



FOR STATE HEALTH DEPT.

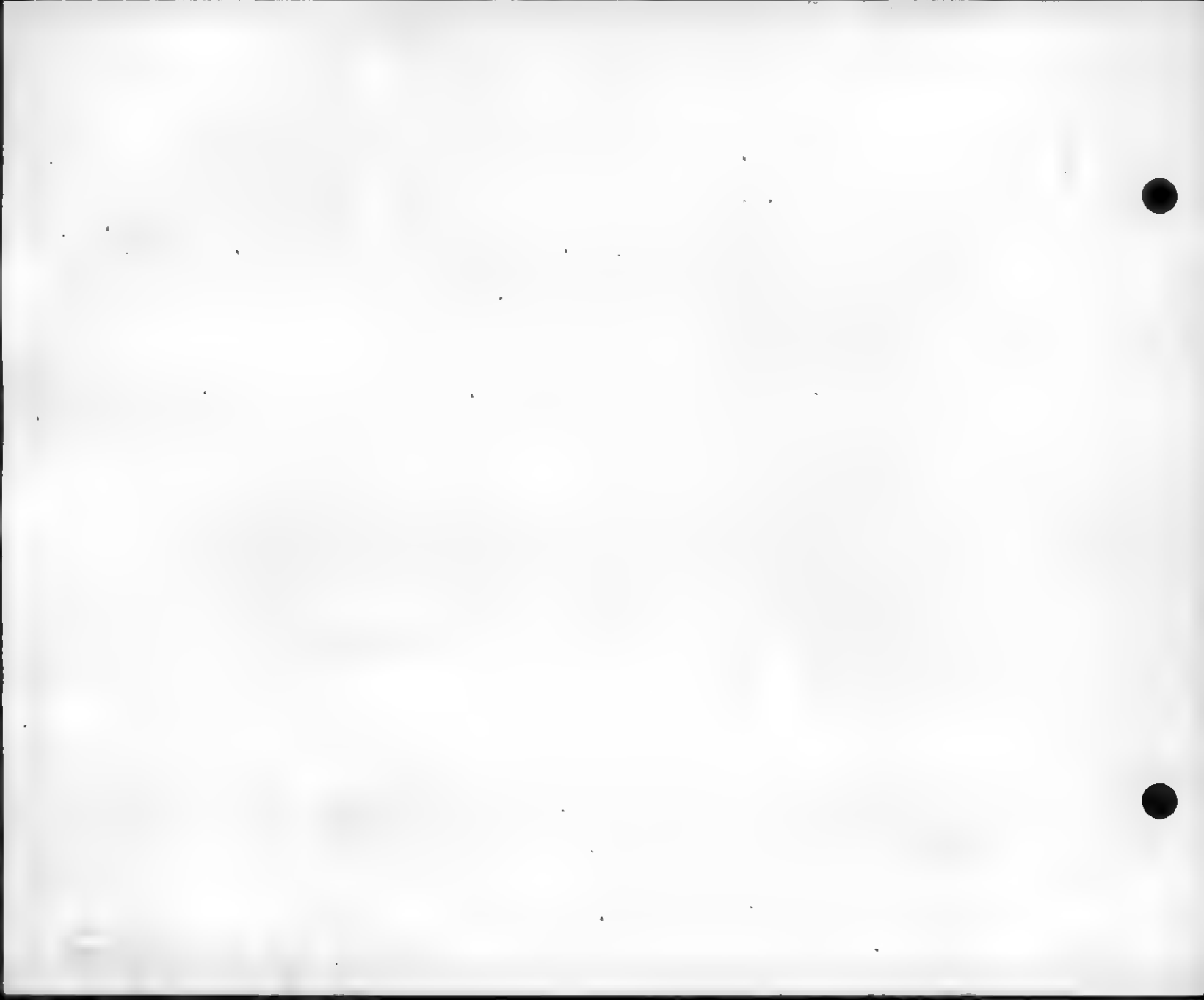
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) THOMAS Lee MALONEY			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 12 Year 1968			2b. HOUR OF DEATH 12:45 P.M.		
3 SEX male	4 RACE white	5 DATE OF BIRTH Feb. 16, 1920	6 AGE (in years last birthday) 47 1/2 RS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April Day 12 Year 1968		
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Procurement Mgr.		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Towson		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 928 Beaverbank Circle					
14. FATHER'S NAME First Middle Last Deforest Maloney				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Shull				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes			16b. SOCIAL SECURITY NO. 294-03-2838		17. INFORMANT ADDRESS Joan E. Maloney, 928 Beaverbank Circle, Towson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4221								APPROXIMATE IN MONTHS BETWEEN ONSET AND DEATH 12
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) Fracture of Clavicle and Pulmonary Emphysema								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day Year HOUR A.M. UNKN P.M. 4/12 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subj. fell off ladder			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State Towson Baltimore, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/13/68		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
ADDRESS (Street, city, town, or county)			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 16, 1968		
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			23e. REC'D BY REGISTRAR APR 17 1968		
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland			25a. REGISTRAR'S SIGNATURE Charles Judge					



Page 4 may be retained by the hospital or attending physician.

15 (4)
EV. 1/68

VR A15 (4)
OM REV. 1/68

15 (4)
EV. 1/68

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First Middle Last		2a DATE OF DEATH Month Day Year		2b HOUR M	
Marion		D. Malpass		April 5, 1968			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 4-10-1898		6 AGE (In years last birthday) 69 YRS.	
7a BIRTHPLACE (State or foreign country) N. Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Summit Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired). Self Employed-Furniture Bus.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Balto		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 3807 Beech Avenue		14 FATHER'S NAME First Barry Wright Malpass		15 MOTHER'S MAIDEN NAME First Katie Pope		15b ADDRESS Hester Malpass-3807 Beech Avenue	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO 213-03-5505		17 INFORMANT Address Hester Malpass-3807 Beech Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 ARTERIOSCLEROTIC CV Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 11-1-68		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MOST					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/100, 1968, to 4/5, 1968, that (I) (we) last saw the deceased alive on 4/4/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Thos. E. Roach		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/5/68	
22d. PHYSICIAN'S NAME (Type) Thos. E. Roach		22e. ADDRESS 3550 Baltimore Ave					
23a BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b DATE 4-8-68		23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Ellsworth Armacost 4600 Liberty Hghts, Avenue		ADDRESS		25a. REC'D BY REGISTRAR APR 9 1968		25b. REGISTRAR'S SIGNATURE John Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

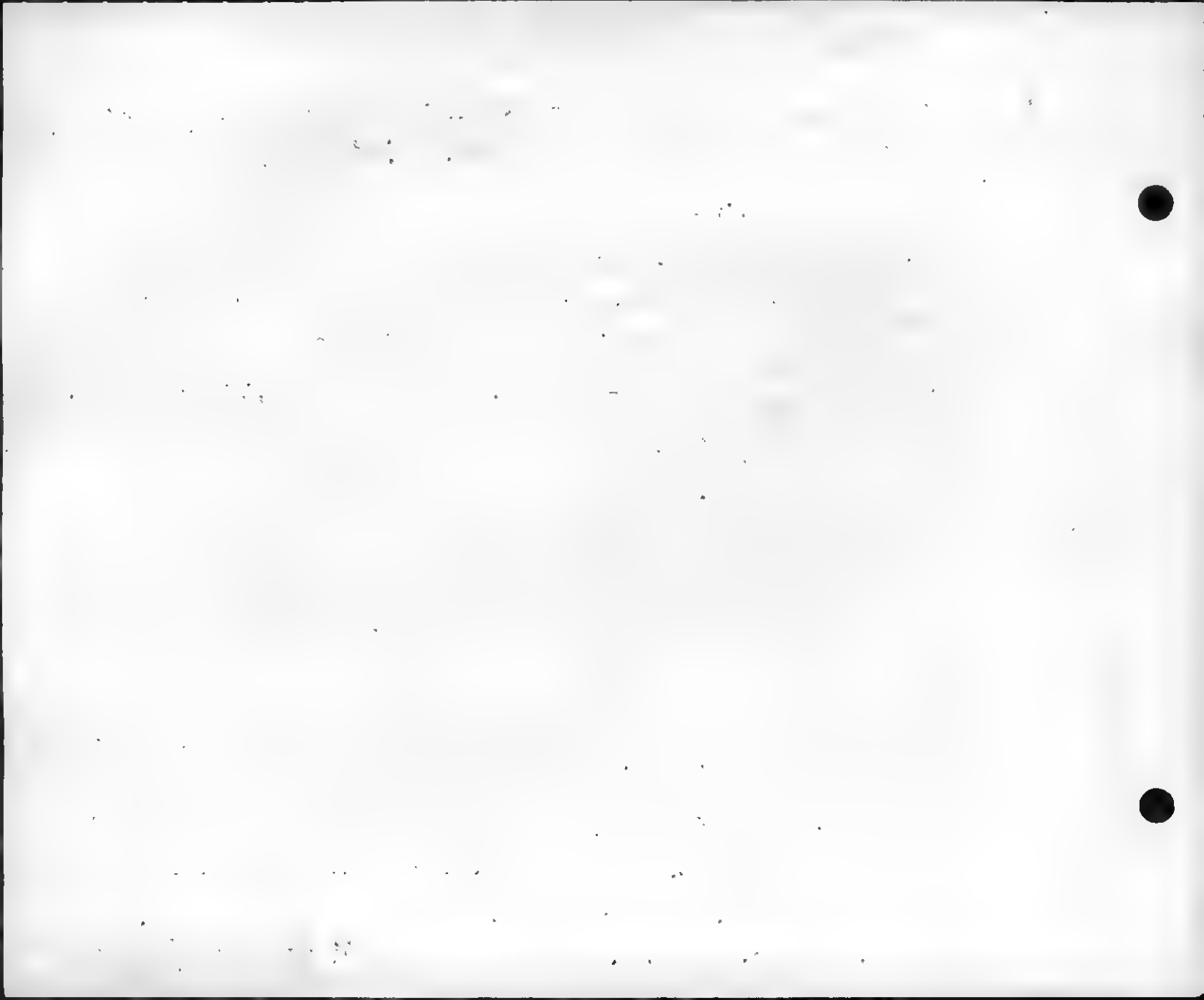
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05303

05303

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
LENA				MANNACAPPELLI	April 16 1968		8:45 PM	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
FEMALE	WHITE		Aug. 3 1890		52 77 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Italy		Italy				Baltimore Md.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a JSJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph Hospital		Tailor Shop				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland		Baltimore		Baltimore				8005 High Point Road
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT
Phillip		Rosaria				215-09-1221		Mrs. Josephine Anzalone, 1738 Amuskai Rd. #34
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> (d) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town County State		
				Street or R.F.D. No				
22a. I certify that (a) (this hospital) attended the deceased from <u>March 30</u> , 19 <u>68</u> , to <u>April 16</u> , 19 <u>68</u> , that (b) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>68</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f DEGREE
<i>Yusup Oh, M.D.</i>		4/16/68		Yusup Oh, M.D.		7620 York Rd., Towson, Md. 21204		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		23e REC'D BY REGISTRAR
Burial		4/20/68.		Holy Redeemer Cemetery		Baltimore, Md.		DATE
24. FUNERAL DIRECTOR		ADDRESS		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Baltimore, Md. 21214				APR 18 1968		<i>John J. Judge</i>		



FOR STATE HEALTH DEPT.

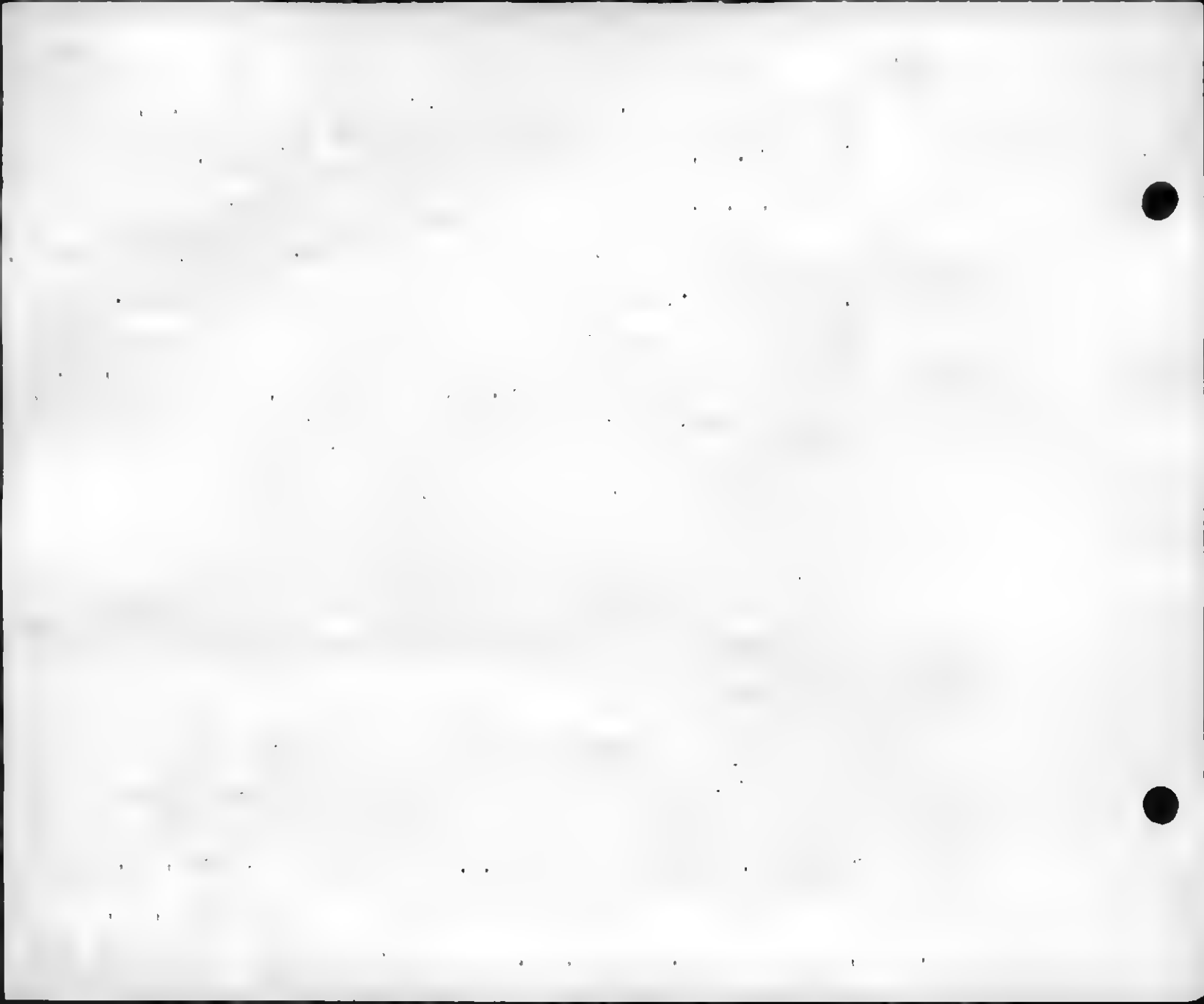
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Stanley J. Maranovich			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Apr. 6, 19 68			2b HOUR M			
3 SEX Male	4 RACE White	5 DATE OF BIRTH Aug. 12, 1902	6 AGE (in years last birthday) 65 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD Month Day Year April 8, 19 68			
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10 CITY OR TOWN OF DEATH Edgemere		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3100 Riverdrive Road			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Turn Foreman - Bethlehem Steel Co		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Edgemere		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3100 Riverdrive Rd.	
14 FATHER'S NAME First Middle Last Dominic Maranovich			15 MOTHER'S MAIDEN NAME First Middle Last Louise Grudzinski			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) No			
16b SOCIAL SECURITY NO 213-07-6758			17 INFORMANT (Wife) Mrs. Elvera Maranovich, 3100 Riverdrive Rd.			ADDRESS Edgemere, Md.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>HCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>HCVD</u> DUE TO OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>									
19a DATE OF OPERATION			19b COND TION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Theodore C. Patterson</u> M.D. EXAMINER'S NAME (Type) Theodore C. Patterson M.D. ADDRESS (Street city town, or county) Dundalk, Md. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b DATE SIGNED 4/6/68 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 4/10/68			23c NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary			
23d LOCATION (City or Town) (County) (State) Baltimore, Md.			24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			25a REC'D BY REGISTRAR DATE APR 15 1968			
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

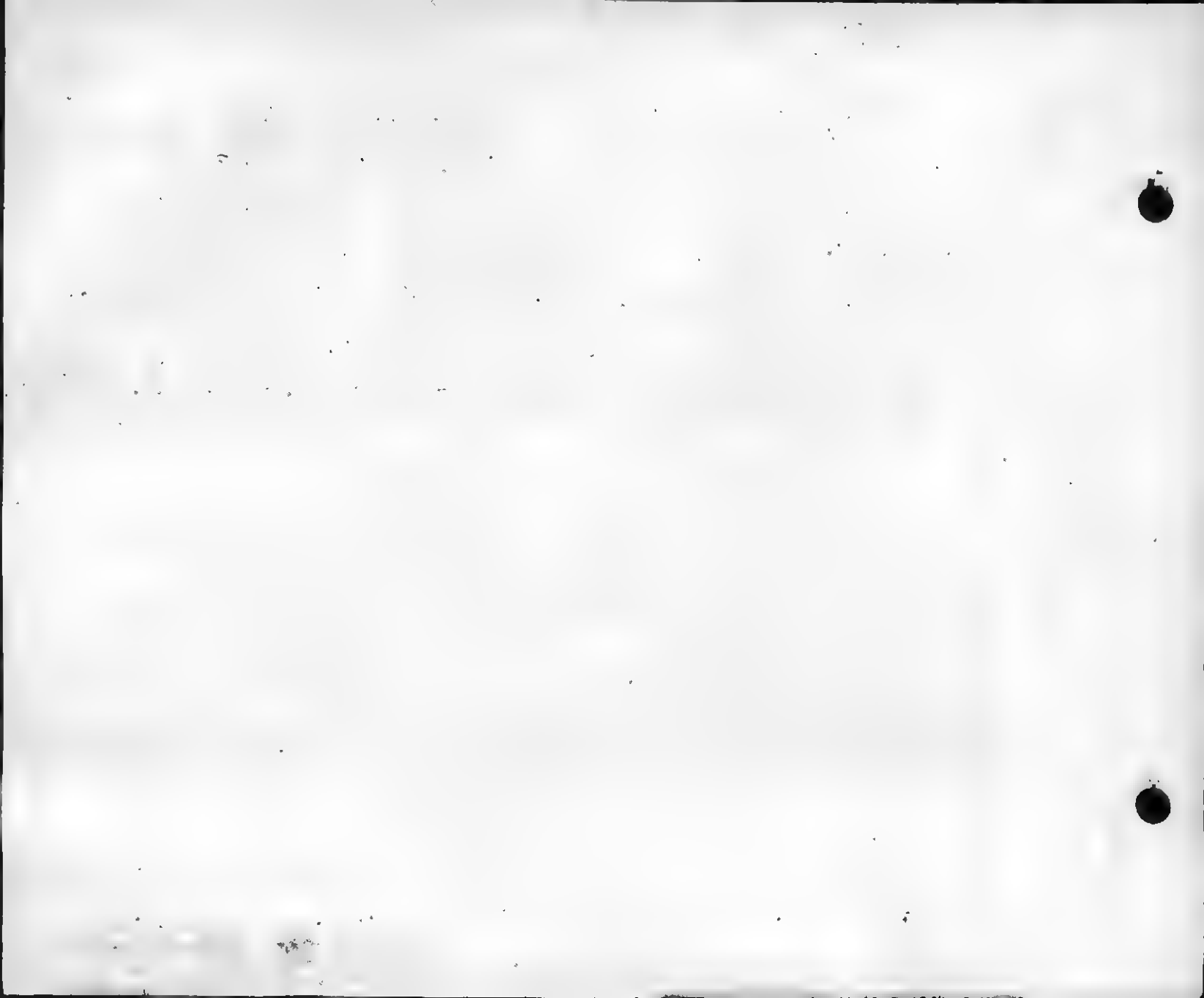
25305

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

25305

1 DECEASED NAME (Type or print) William Braddy Mason			2a. DATE OF DEATH Month April Day 14 Year 1968			2b. HOUR 3:30 M	
3. SEX male		4. RACE negro		5. DATE OF BIRTH May 10 1900		6. AGE (In years last birthday) 67 YRS	
7a. BIRTHPLACE (State or foreign country) Worcester		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore CO.	
10. CITY OR TOWN OF DEATH Garrison Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forleigh Cons. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dentist		12b. KIND OF BUSINESS OR INDUSTRY Professional	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD CITY Baltimore		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3501 Foxcliff Court							
14. FATHER'S NAME First William Middle B Last Mason			15. MOTHER'S MAIDEN NAME First Lucy Middle J Last Marlow				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 214-40-6526 A		17. INFORMANT Frederick B. Brown		Address 5213 12th St. N.E. Wash.D.C.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - Probable 185X DUE TO, OR AS A CONSEQUENCE OF metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from Jan 24, 1967 to April 14, 1968 , that (I) (we) last saw the deceased alive on April 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Leon G. Sheer MD DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 14 April 1968	
22d. PHYSICIAN'S NAME (Type) LEON G. SHEER, MD						22e. ADDRESS 6715 PARK HEIGHTS AVE.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/68		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Sutland Maryland	
24. FUNERAL DIRECTOR Nutter Funeral Home - 3035 W. North Ave.				25a. REC'D BY REGISTRAR APR 22 1968		25b. REGISTRAR'S SIGNATURE John J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

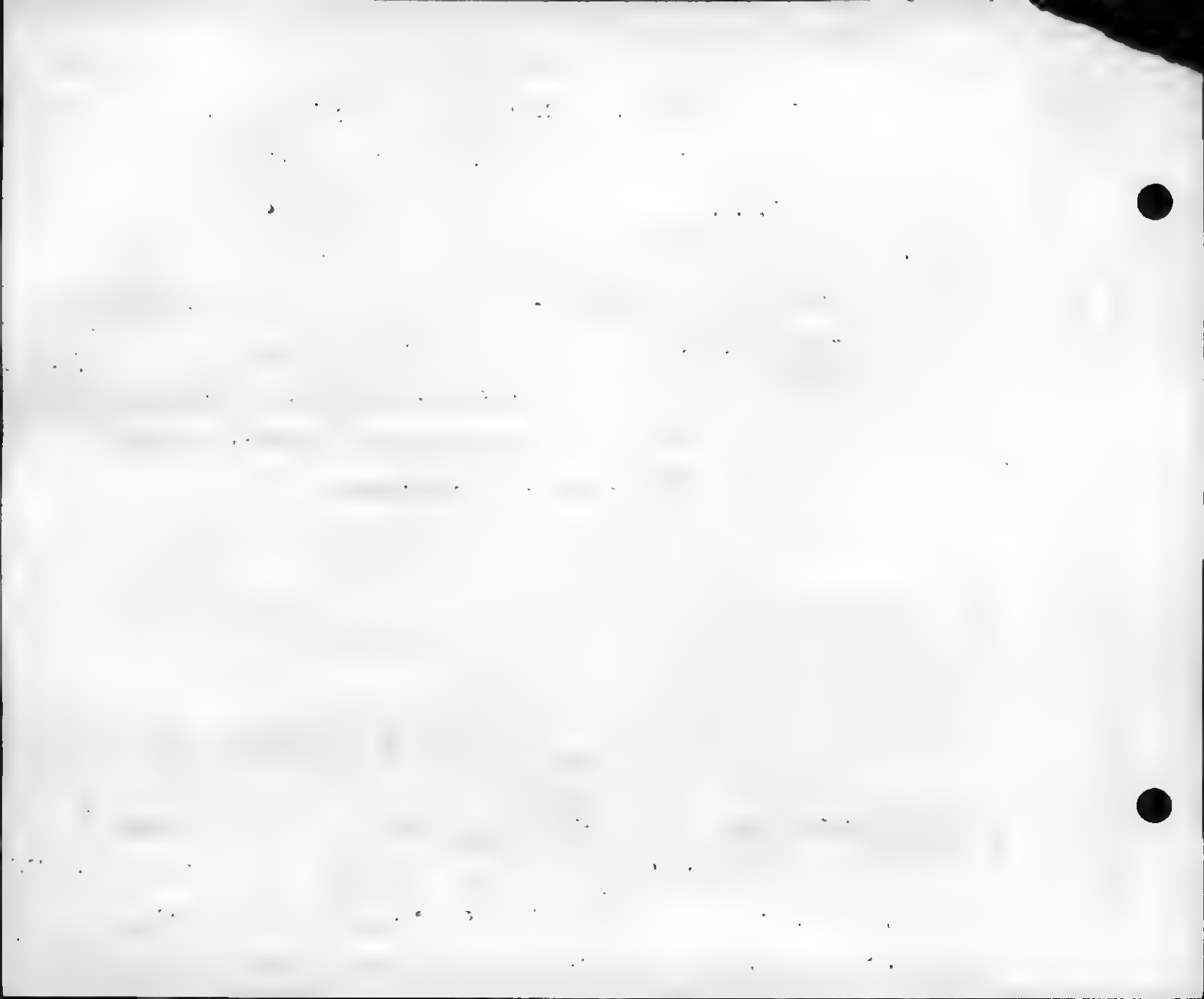
05306

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05306

1. DECEASED NAME (Type or print) ANNIE KATHERINE MATTINGLY			2a. DATE OF DEATH Month April , Day 21 , Year 1968			2b. HOUR 7:30 AM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH July 5, 1885		6. AGE (In years last birthday) 82 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Arbutus		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4720 Gateway Terrace		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 4720 Gateway Terrace		14. FATHER'S NAME First William F. Middle Keys Last Keys		15. MOTHER'S MAIDEN NAME First Agnes Middle Brautigam Last Brautigam			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. Carl G. Mattingly, 4720 Gateway Terrace		Address 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1967 , to 4.21.1968 , that (I) (we) last saw the deceased alive on 4.21.1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stanley Ankudas DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4.22.68			
22d. PHYSICIAN'S NAME (Type) Dr. Stanley Ankudas				22e. ADDRESS 1101 Maiden Choice Lane, Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-24-1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



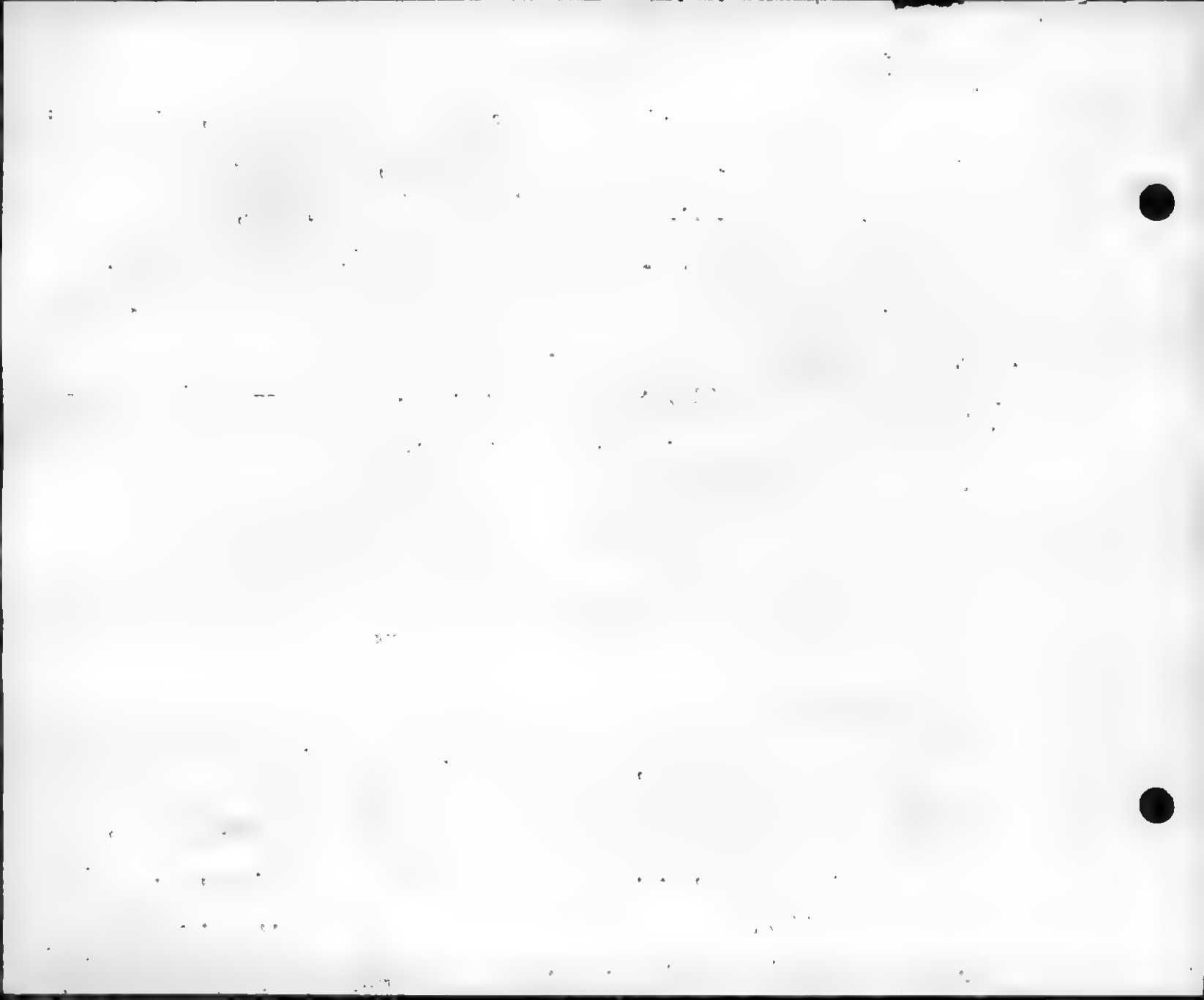
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VR A15 (M)
30M REV. 1/68

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P	
FRANK		JAMES	McMAHON	APRIL 28, 1968		10:20		
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		JANUARY 31, 1909		59 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
VIRGINIA	U.S.A.		BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		SUPERVISOR		BETH. STEEL		
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L.M. 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND		BALTIMORE		DUNDALK		3311 DUNDALK AVE. #21222		
4. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last						
FRANK J. McMAHON, Sr.		EUGENIA JACKSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO		213/09/3758		MILDRED M. McMAHON--AS IN (# 13 a-e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) _____								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <u>APRIL 5, 1968</u> , to <u>APRIL 28, 1968</u> , that (1) (we) lost saw the deceased alive on <u>APRIL 28, 1968</u> , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Ismael Jamora</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>APRIL 28, 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>ISMAEL JAMORA, M.D.</u>						22e. ADDRESS <u>7620 YORK ROAD TOWSON, MD. #21204</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		5/2/1968		OAK LAWN		BALTO., CO. MARYLAND		
24. FUNERAL DIRECTOR <u>W. Brooks Bradley</u> ADDRESS <u>DUNDALK, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE HEALTH DEPT.

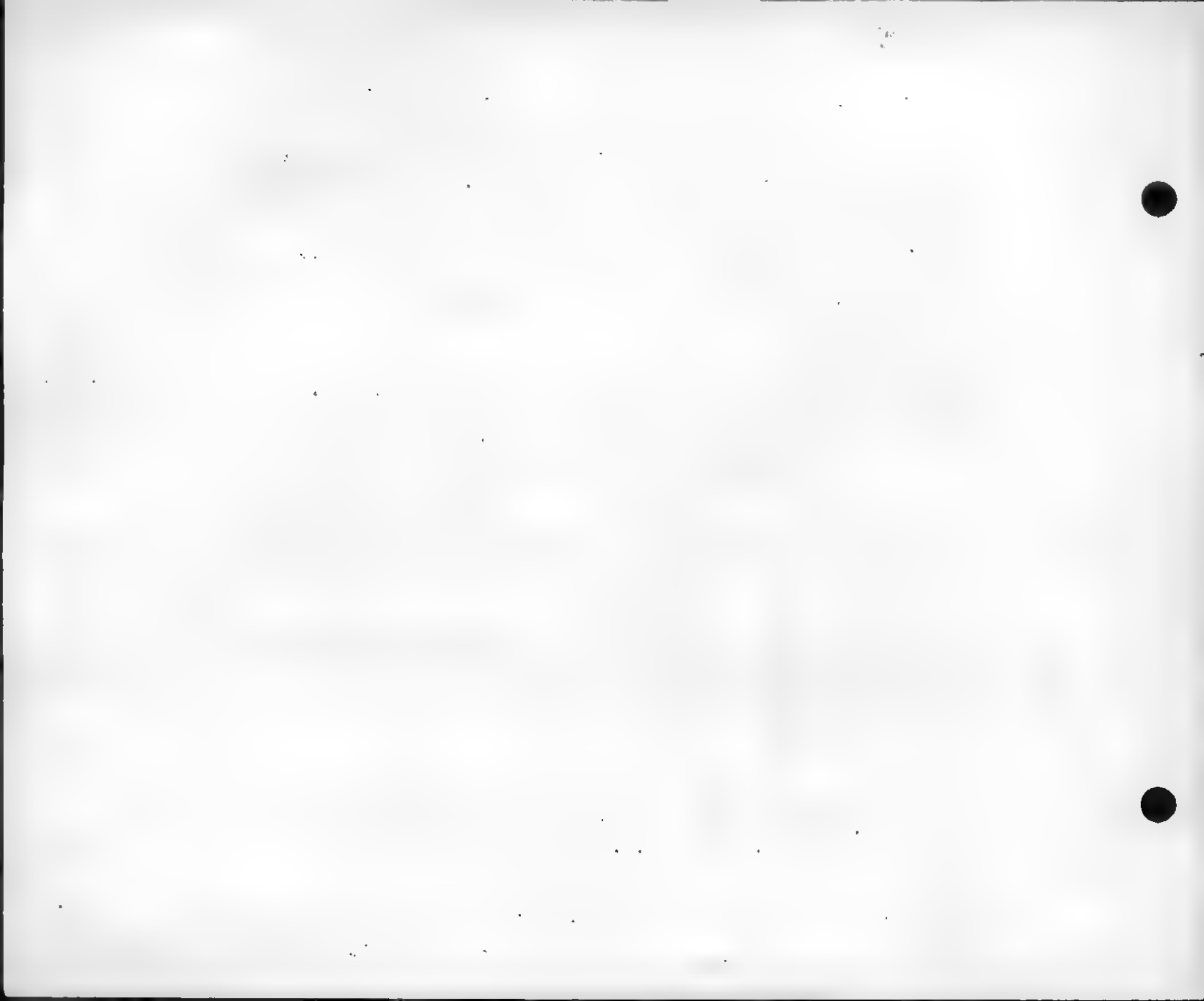
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form B-3, Page 5 may be retained for your files.

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25308

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI-DEATH MATED		Month	Day	Year	2b HOUR
HARRIETTE		ELIZABETH	MC MAHON	2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Female	White	12-8-1910	57 YRS	MONTHS	DAYS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MD.		U.S.A.				BALTIMORE				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Pikesville			9 Randall Avenue			HOUSEWIFE			HOME	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Baltimore			Pikesville			9 Randall Avenue	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO	
William W. HOLLAND			Ettie Mills			Mrs. EDWARD KAZMIERKI			SILVER Spring MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4221										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
				HOUR A.M. P.M.		19				
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED		
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				April 10, 1968		
Werner U. Spitz, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)		
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
BURIAL		4-18-68		MEADOWBRIDGE		ELK RIDGE				MD.
24 FUNERAL DIRECTOR		25a RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
John W. Lyons		APR 23 1968		Charles Judge						



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

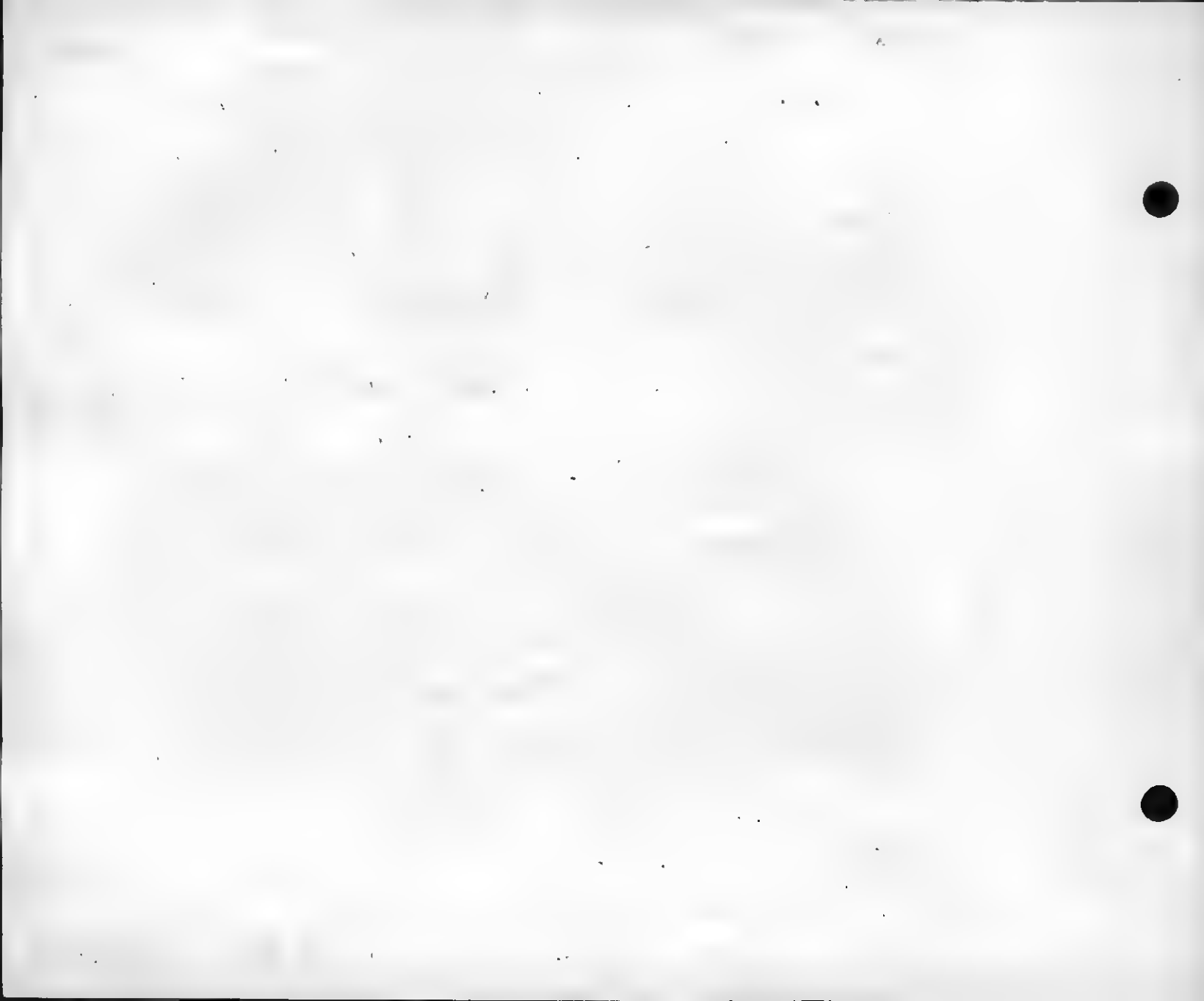
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

20308

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) MARGARET ANNE MERRYMAN				2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> DAY 20 Year 1968				2b HOUR 3 P.	
3 SEX F	4 RACE W	5 DATE OF BIRTH 4-18-03	6 AGE (in years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c DATE PRONOUNCED DEAD Month April Day 20 Year 1968		2d HOUR 6 P.	
7a BIRTHPLACE (State or foreign country) MD		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH PHOENIX		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) PHOENIX RD.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE M		13b COUNTY BALTO		13c CITY OR TOWN PHOENIX		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER RT 1 BOX 88	
14 FATHER'S NAME First Middle Last 				15. MOTHER'S MAIDEN NAME First Middle Last 					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 		16b SOCIAL SECURITY NO NONE		17 INFORMANT MARY E. MYERS				ADDRESS RT 1 BOX 88	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) 443x									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE William A. Pillsbury				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 4-20-68	
EXAMINER'S NAME (Type) William A. Pillsbury				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, or County)			
23a BURIAL CREMATION REMOVE (Specify) BURIAL		23b DATE APR 23/68		23c NAME OF CEMETERY OR CREMATORY SATER'S		23d LOCATION (City or Town) BALTO CO		(County) (State)	
24 FUNERAL DIRECTOR Paul C. Chmura				ADDRESS 3615 The Wood Ave		25a REC'D BY REGISTRAR APR 23 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



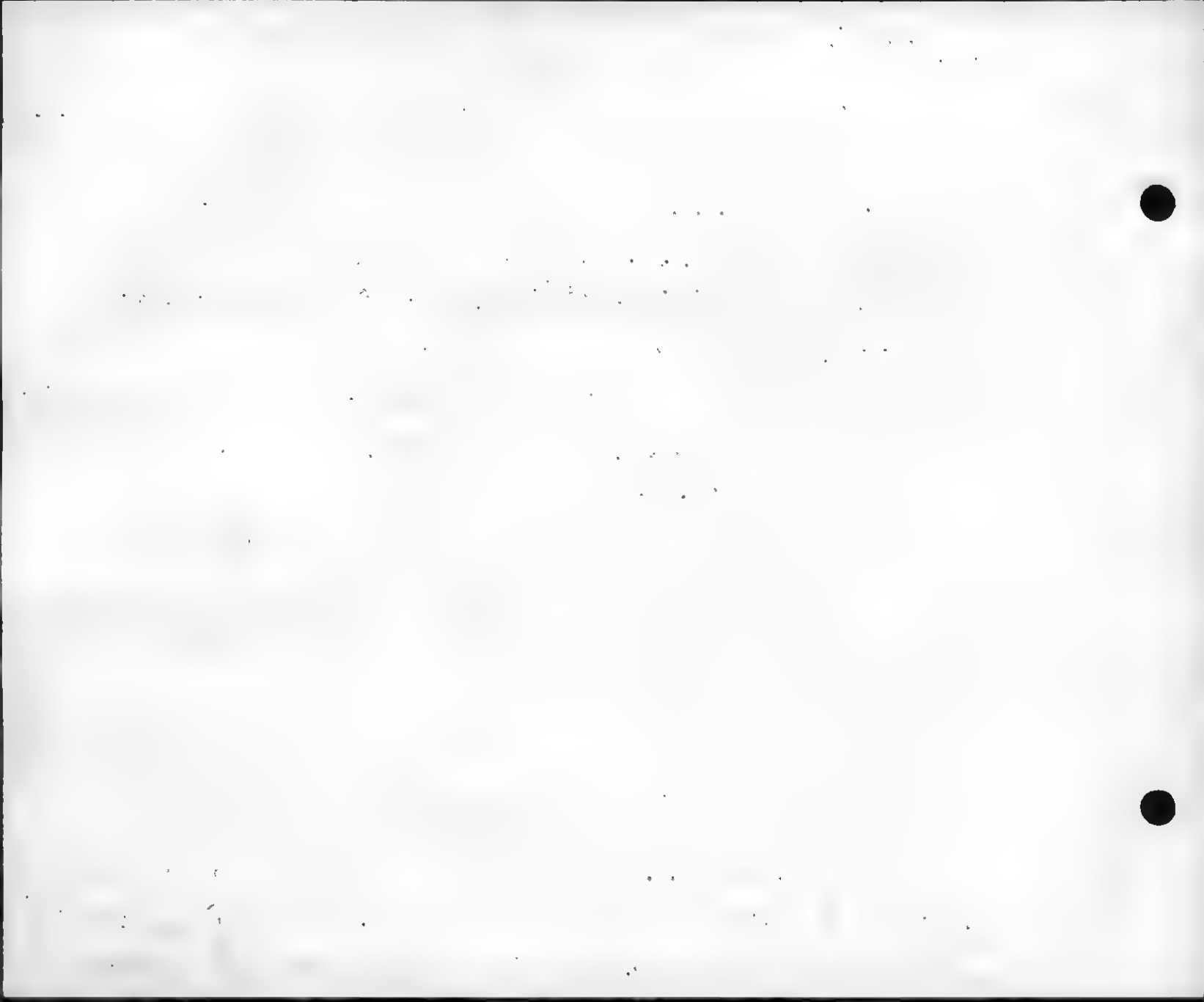
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Margaret		First Ann		Middle Metzdorf		Last		2a. DATE OF DEATH Month April Day 20 Year 68			2b. HOUR 4.50PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-29-78			6. AGE (in years lost birthday) 89 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Wife			12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USCA. RES. DENCE (Where deceased admission) STATE Maryland		13b. COUNTY QUEEN ANNES'S		13c. CITY OR TOWN QUEENSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER [REDACTED]				
14. FATHER'S NAME First FRANK Benjamin Anthony		Middle		Last		15. MOTHER'S MA DEN NAME First Sarah		Middle -		Last Dixon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-52-8084		17. INFORMANT Daughter		Address Mrs. William T. Bookers 2605 Windsor Ave. Parkville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Massive pulmonary atelectasis.												
DUE TO, OR AS A CONSEQUENCE OF												
(b) Thromboembolism.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 3/29/ , 19 68 , to 4/20/ , 19 68 , that (I) (we) lost saw the deceased alive on 4/20/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Cilliani		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-21-1968						
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.		22e. ADDRESS 7620 York Rd., Towson, Md., 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE April 24, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION (City or Town) QUEENSTOWN		(County) QUEEN ANNES'S		(State) Md.		
24. FUNERAL DIRECTOR James H. Butler Jr. - Butler Bros., Centerville, Md.		ADDRESS		25a. REC'D BY REGISTRAR APR 26 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

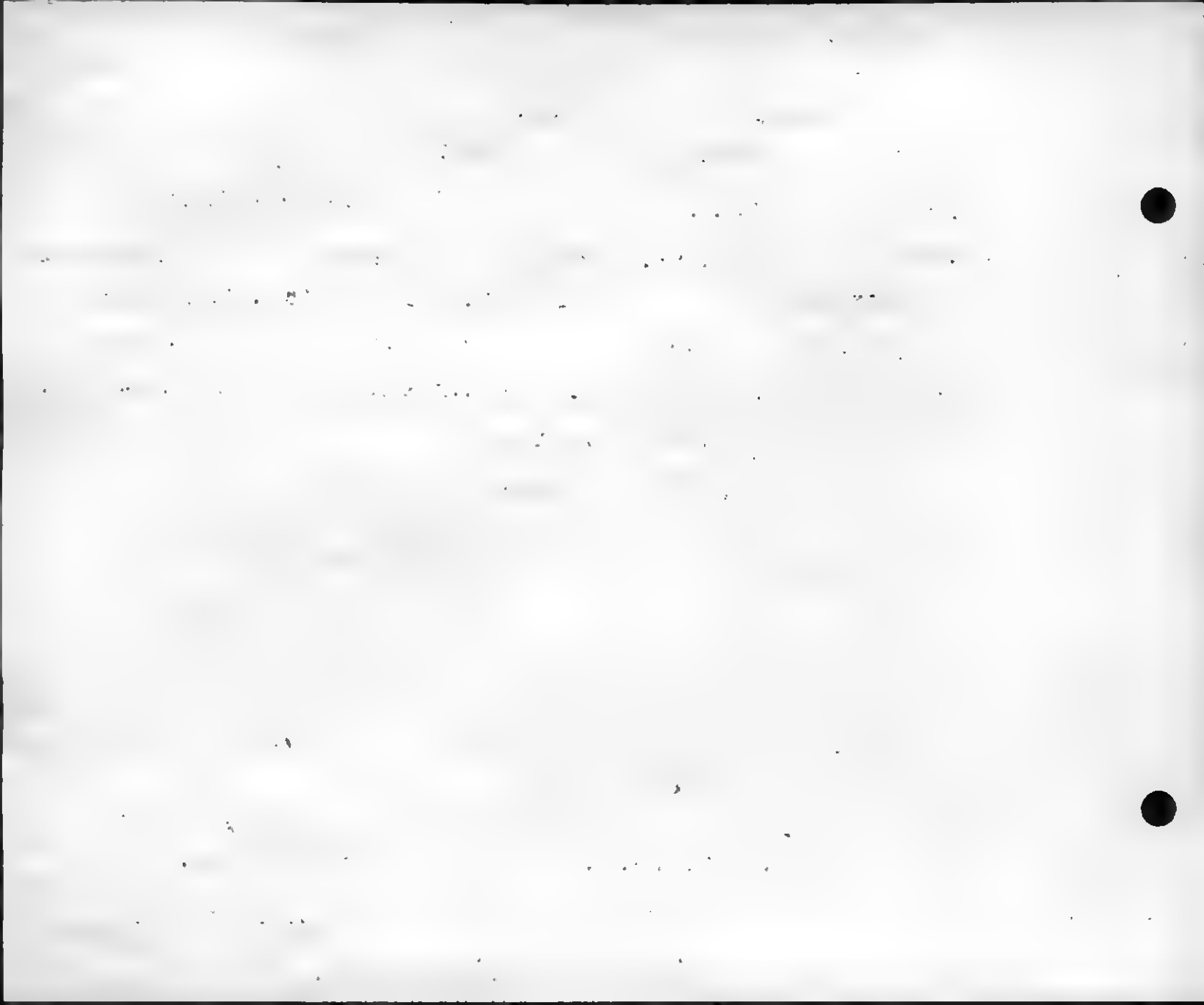
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05313

1. DECEASED-NAME (Type or print) LAWRENCE			First Middle Last			2a. DATE OF DEATH Month Day Year 4 4 68			2b. HOUR 10:00AM		
3. SEX MALE			4. RACE NEGRO			5. DATE OF BIRTH 10/16/22			6. AGE (In years last birthday) 45 YRS.		
7a. BIRTH-PLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md		
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY 6			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Robert Mickey			15. MOTHER'S MAIDEN NAME First Middle Last Annie Cheatham								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) <input checked="" type="checkbox"/> (If yes give year or dates of service) WW II			16b. SOCIAL SECURITY NO 214 12 15 84			17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF STOMACH DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. 15/18										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BRONCHOPNEUMONIA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from 3/15/68 , 19__, to 4/4/68 , 19__, that (b) (we) last saw the deceased alive on 4/4/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. D. Talbert, MD. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED 4/4/68		
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.									22e. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-8-68			23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR			ADDRESS Collick Funeral Home			25a. DAY OF REGISTRATION APR 8 1968			25b. REGISTRAR'S SIGNATURE [Signature]		
1112 E. Preston St. Baltimore, Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <i>Eleanor J. Miguel</i>			First Middle Last			2a. DATE OF DEATH Month <i>April</i> Day <i>27</i> Year <i>1968</i>			2b. HOUR <i>6:15 PM</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 20, 1898</i>			6. AGE (In years last birthday) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore County Md.</i>				
10. CITY OR TOWN OF DEATH <i>Catonville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>clerk - bank</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>clerk</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <i>95 Wickham Rd. 21229</i>	
14. FATHER'S NAME <i>William S. Jeffreys</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Adelia L. Coleman</i>			First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO. <i>212-12-4696</i>			17. INFORMANT <i>Mr. Eugene L. Kraft-3712 Somerset Ave.</i>			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years +</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Acromegaly</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <i>Jan 63</i> to <i>April 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 26, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.													
22b. SIGNATURE <i>James Nolan</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>4/29/68</i>							
22d. PHYSICIAN'S NAME (Type) <i>J. J. NOLAN</i>			22e. ADDRESS <i>Baltimore Md 21229</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>			23b. DATE <i>4-30-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Bald. Md.</i>				
24. FUNERAL DIRECTOR <i>John J. Conroy & Co. Catonsville Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR DATE <i>MAY 2 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

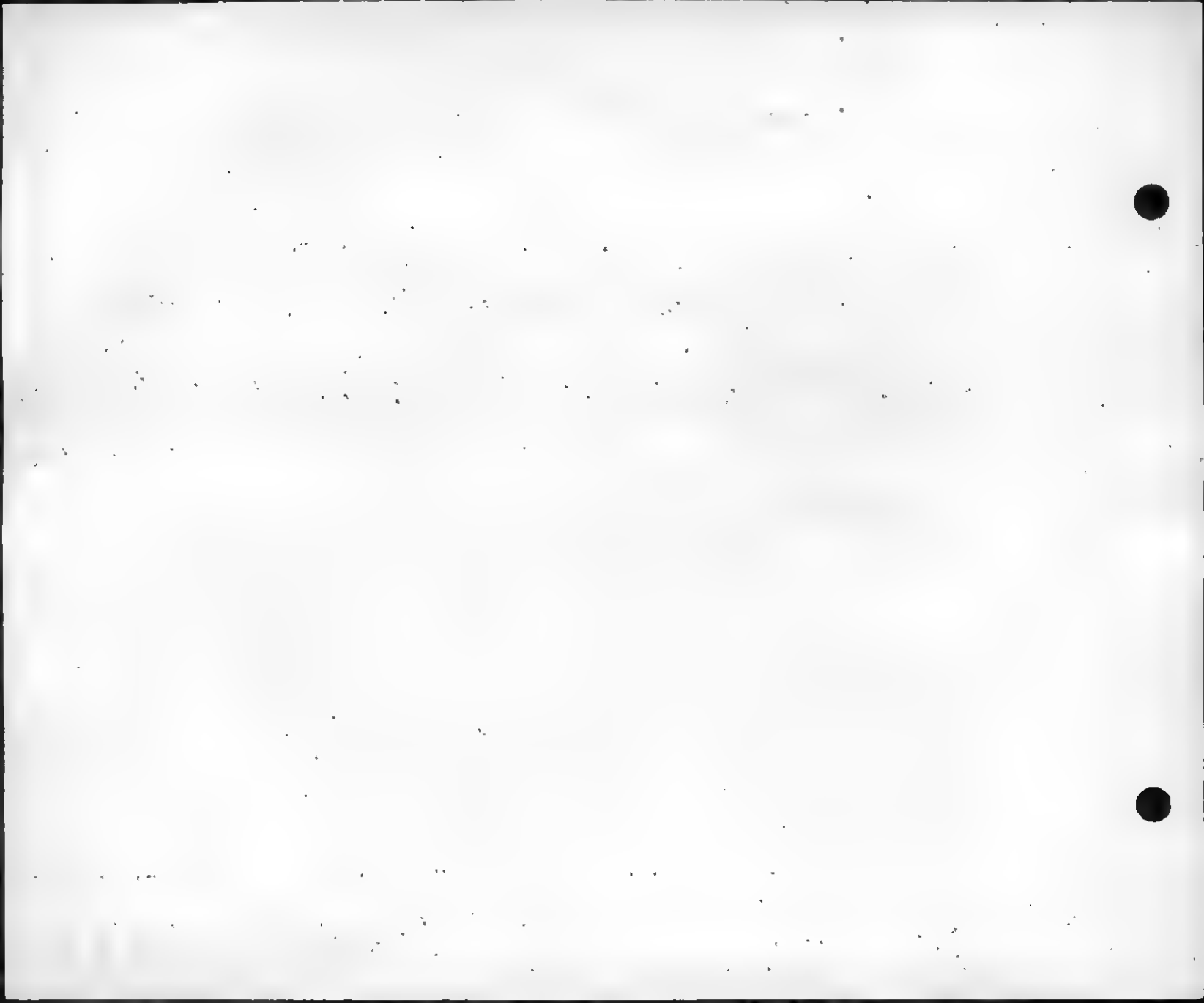
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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Howard Leonard Miller		Howard	Leonard	Miller	Month	Day	Year	6:30 AM
3 SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
M	W	3-28-1901			67 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Md.		USA				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Crescent Mt. Home			Truck Driver		Trucking	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
ma		Balto.		Monkton		YES <input type="checkbox"/> NO <input type="checkbox"/>		York Rd.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
3 Howard Miller		Temper Mayes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT				
NO		215-10-7471A		Daisy B. Miller; York Rd Monkton Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>								Years -
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u>								Hours -
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Cerebral Vascular Accident</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>68</u> , to <u>4/14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Luis J. Elias M.D.</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/15/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>LUIS J. ELIAS, M.D.</u>				22e. ADDRESS <u>1701 Meridene Drive, Balto., Md. 21212</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>		<u>4/18/68</u>		<u>Hereford Baptist Cem</u>		<u>Parkton, Balto. Md.</u>		
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>DATE APR 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		



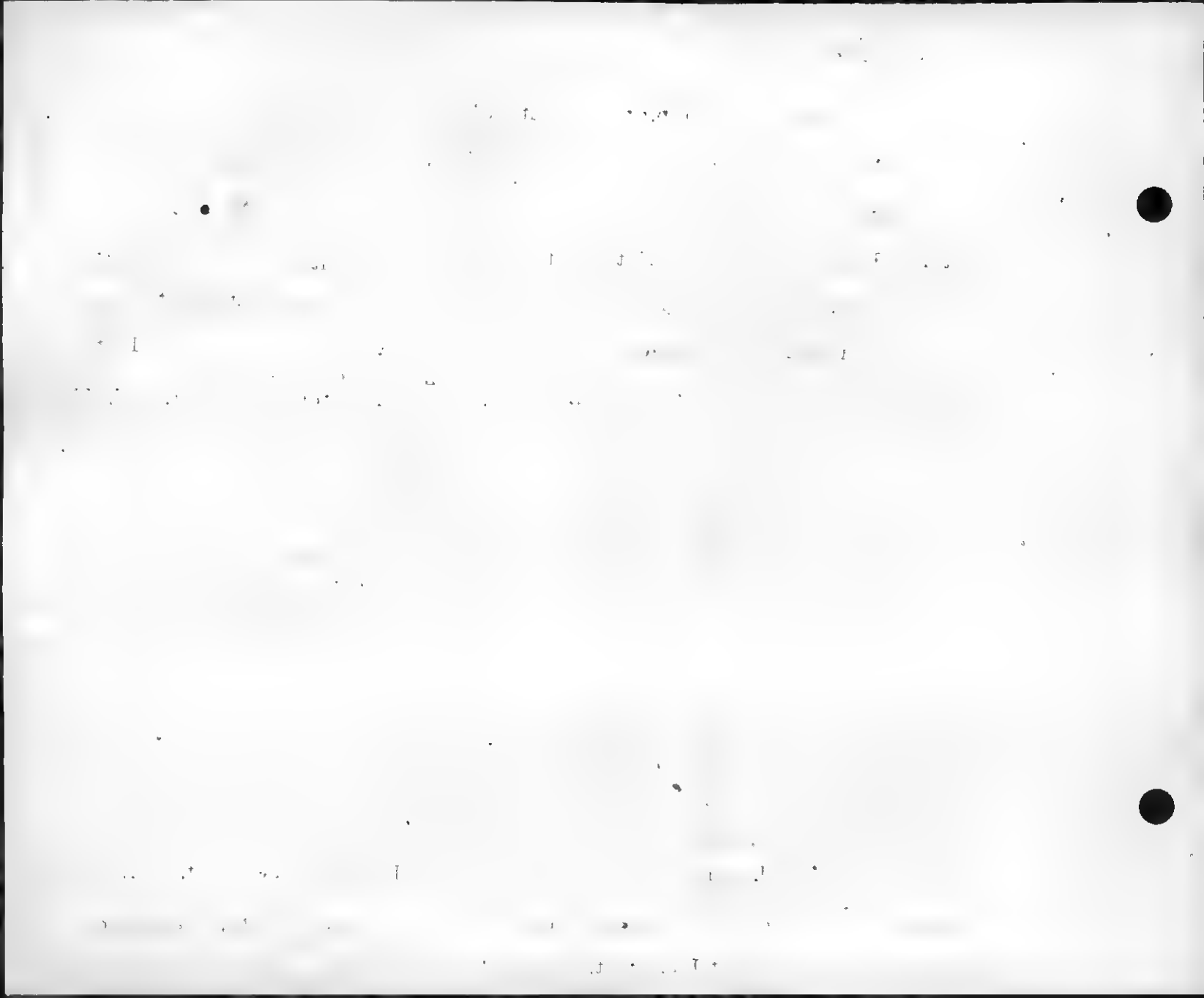
85314

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Henry James Mitchell			2a. DATE OF DEATH Month Day Year 4 25 68			2b. HOUR M 6				
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH 4/8/86		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1215 Kiethmont Rd			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auditor			12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1215 Kiethmont Rd	
14. FATHER'S NAME First Middle Last William Mitchell			15. MOTHER'S MAIDEN NAME First Middle Last Nellie Bulpitt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 215-01-7324		17. INFORMANT Address 1215 Kiethmont Rd Mrs. Lena L. Mitchell Balt. Md. 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage 4017 DUE TO, OR AS A CONSEQUENCE OF Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 years (c) 10 years									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous Cerebral Vaso. accident in 1964										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Nov. 1964 , to April 1968 , that (I) (we) last saw the deceased alive on April 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Max J. Miller						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/26/68		
22d. PHYSICIAN'S NAME (Type) Max J. Miller						22e. ADDRESS 1047 Ingleside Ave Balt. Md. 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City or Town) (County) (State) AA County, Maryland			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks West Inc. Balt. Md. 21228						25a. REC'D BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be emitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

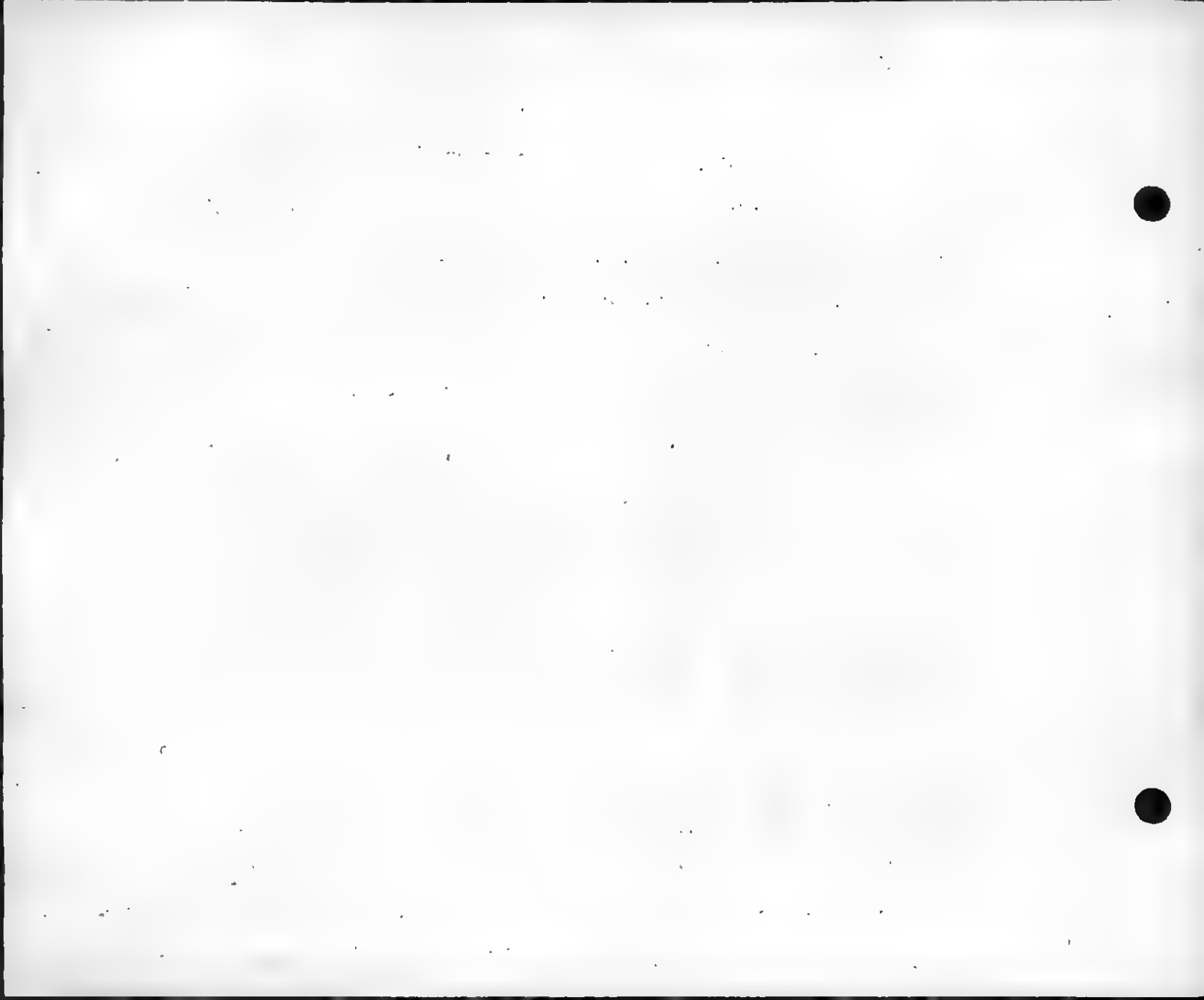
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G399 4/26/68 kk **CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First Middle Last JOHN PENSE MOLLETT			2a. DATE OF DEATH Month Day Year 4 18 68			2b. HOUR 3:25 PM					
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 12-19-1920		6. AGE (in years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) India		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 205 Duke of York Lane		
14. FATHER'S NAME First Middle Last John Donald Mellott			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Pence								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 212 34 3665			17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malignant melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/18, 1968</u> to <u>4/18, 1968</u> , that (I) (we) lost saw the deceased alive on <u>4/18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John E. Adams</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/18/68			
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.						22e. ADDRESS Greater Baltimore Medical Center					
23a. BURIAL, CREMATION, REMOVAL, or other disposal Burial			23b. DATE 4-22-68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION (City or Town) (County) (State) Cockeysville, Baltimore, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204						25a. REC'D BY REGISTRAR DATE Apr 23 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last Harry E. Mooneyhan		2a. DATE OF DEATH Month Day Year 4 8 1968		2b. HOUR 7A M
3 SEX male	4 RACE Cau.	5. DATE OF BIRTH 4-19-1900		6. AGE (In years last birthday) 67 YRS
7a. BIRTHPLACE (State or foreign country) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Fullerton	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4134 Grape Hill	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Self-employed	12b. KIND OF BUSINESS OR INDUSTRY Barbar	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Fullerton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4134 Grape Hill Avenue
14 FATHER'S NAME First Middle Last Henry E. Mooneyhan	15. MOTHER'S MAIDEN NAME First Middle Last Lula Scarborough			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. 215-12-7236	17 INFORMANT Address James N. Mooneyhan 5502 Catalhe Road 21214		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease 24 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic CVD</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from <u>May 13, 1968</u> to <u>April 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>4-2-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above: (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Richard R. Rigler</u>	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/9/68	
22d. PHYSICIAN'S NAME (Type) RICHARD R. RIGLER, M.D.	22e. ADDRESS 1 W. Overlea Ave., Balto 6, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-11-1968	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR <u>Laurel Funeral Home 2401 Belair Road</u>	ADDRESS 21236	25a. REC'D BY REGISTRAR APR 15 1968	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



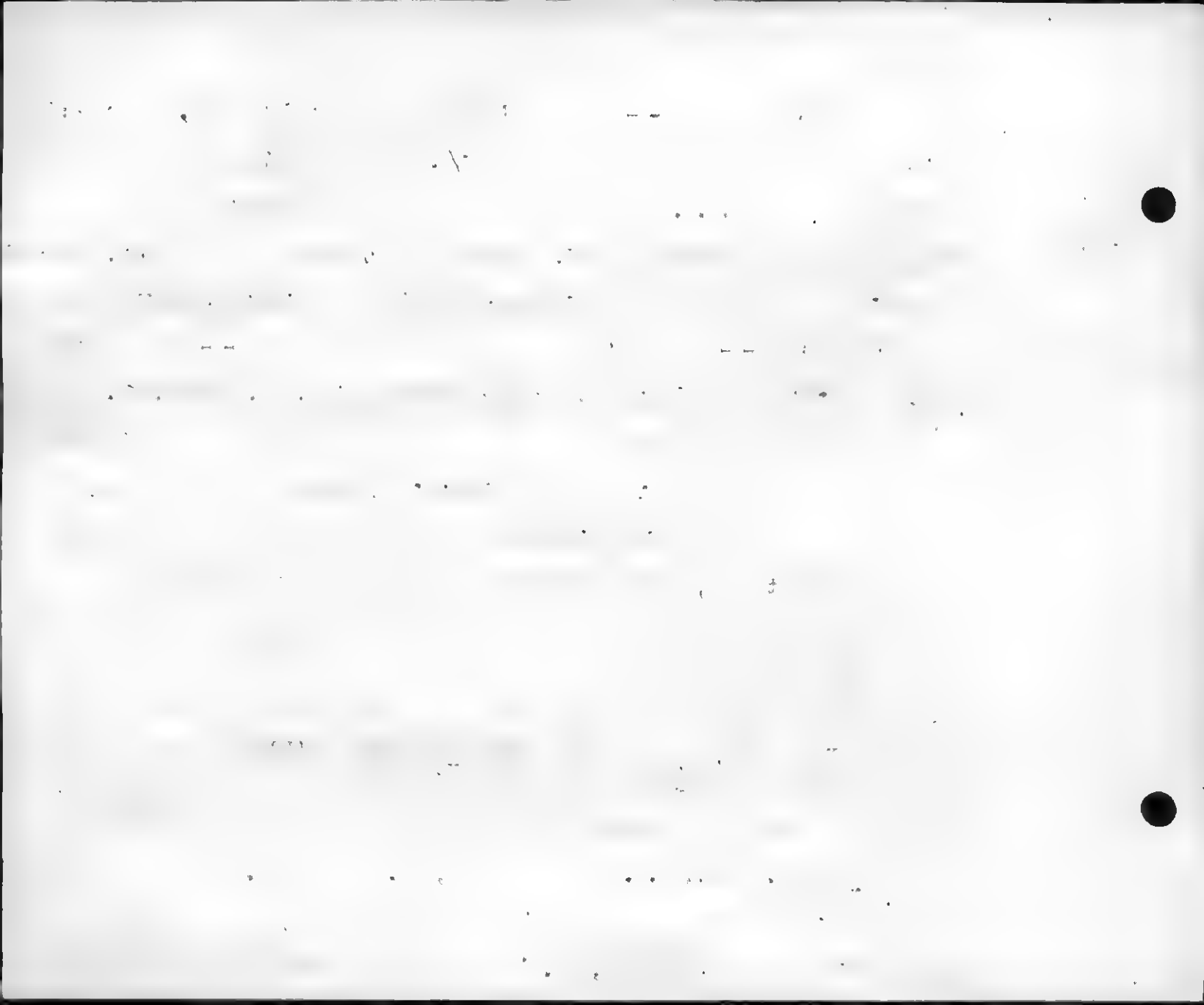
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VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

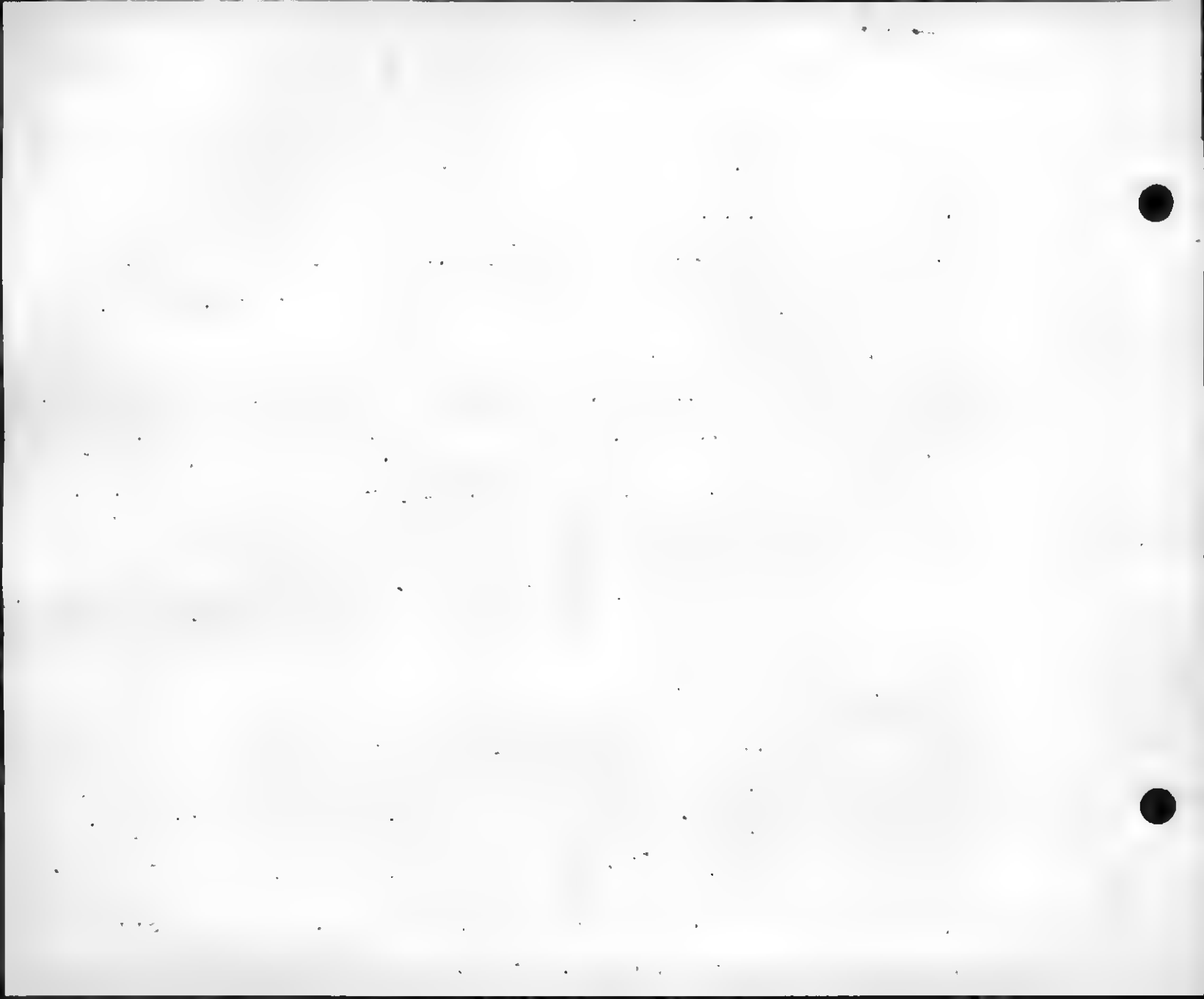
1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 2:00AM	
OLIVER				MOORE	APRIL 28, 1968			
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	NEGRO		8/24/89		78 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b KIND OF BUSINESS OR INDUSTRY	
VIRGINIA	U.S.A.				BALTIMORE		AMER. RADIATOR	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD		VETERANS ADMIN. HOSPITAL		LABORER				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		811 McALEER COURT
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
CLAYBURN				MOORE	ELLA			SCOTT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
YES		213 01 42 05		CLINICAL RECORDS, VAH, FT. HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								2 WEEKS
DUE TO, OR AS A CONSEQUENCE OF								YEARS
DUE TO, OR AS A CONSEQUENCE OF								YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
GANGRENE LEFT 5th TOE, ARTERIOSCLEROSIS OBLITERANS LOWER EXTREMITIES								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from MAR 19, 1968, to APR 28, 1968, that (X) (we) last saw the deceased alive on APR 28, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Elsa M. Goris						22c. DATE SIGNED 4/28/68		
22d. PHYSICIAN'S NAME (Type) ELSA M. GORIS, M.D.						22e. ADDRESS VAH, FT. HOWARD, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Apr 28, 1968		Moore's Cem.		Petersburg VA		
24. FUNERAL DIRECTOR Elroy Wilson				25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		
2001 ORLEANS ST., BALTIMORE, MD.								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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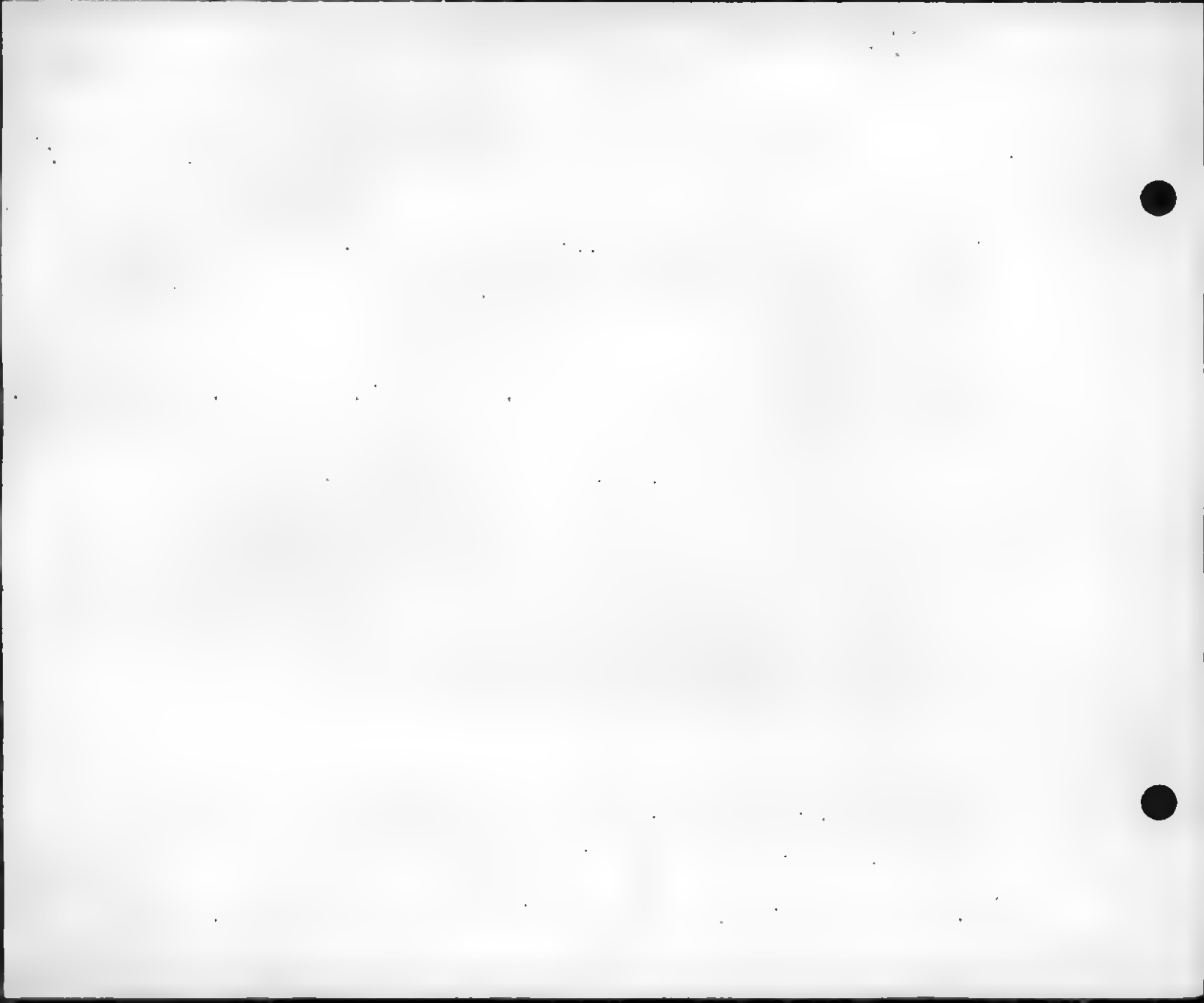
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item 17 Film G399 4/22/68 Kk												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last William Kelso Morrill Sr.						2a. DATE OF DEATH Month Day, 1968 April 11, 1968			2b. HOUR M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Dec. 15, 1903			6. AGE (In years last birthday) 64 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 534 Stevenson La. Pronounced @ St. Jos. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Prof. of Math.			12b. KIND OF BUSINESS OR INDUSTRY University			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 534 Stevenson La.				
14. FATHER'S NAME First Middle Last Bert Morrill				15. MOTHER'S MAIDEN NAME First Middle Last Edna Fort								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 220-30-2822		17. INFORMANT Mary Mrs. Edna C. Morrill wf. 534 Stevenson La.								
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Granulomatous Arteritis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3.5 minutes 2 years		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 1963, to April 1968, that (I) (we) last saw the deceased alive on March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. Gordon Walker M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12 April 1968		
22d. PHYSICIAN'S NAME (Type) W. GORDON WALKER		22e. ADDRESS Johns Hopkins Hospital										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15, 1968		23c. NAME OF CEMETERY OR CREMATORY New London Cemetery		23d. LOCATION (City or Town) (County) (State) New London, Pennsylvania						
24. FUNERAL DIRECTOR Wm. Cook-Brooks, Towson Inc. 1050 N. York Rd.						25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) ELIZABETH MARY MORRIS			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year APR 10 1968		2b HOUR 10A M	
3. SEX F	4 RACE W	5 DATE OF BIRTH 6-30-83	6 AGE (in years last birthday) 84 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year APRIL 10 1968		2d HOUR 10A M	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Cockeysville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 220 Padonia Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Cockeysville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 220 Padonia Road	
14 FATHER'S NAME First Middle Last Frank Measley			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO None		17 INFORMANT ADDRESS Mrs. Paul Morris, Padonia Rd., Cockeysville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4-27								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE William A. Pillsbury		EXAMINER'S NAME (Type) William A. Pillsbury		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 4/10/68	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE April 13, 1968		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d LOCATION (City or Town) (County) (State) Cockeysville, Maryland			
24 FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				ADDRESS		25a REC'D BY REGISTRAR APR 15 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) RITA M. MORRISON			2a. DATE OF DEATH Month April Day 26 Year 1968			2b. HOUR 2:05am			
3 SEX Female		4 RACE White		5. DATE OF BIRTH April 12, 1903		6. AGE (In years last birthday) 65 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1609 Woodbourne Ave. 21212	
14. FATHER'S NAME First Middle Last Wm. E. Connolly				15. MOTHER'S MAIDEN NAME First Middle Last Mary Catherine Whelple					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Doris Anderson-Sister			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Edema 2501 DUE TO, OR AS A CONSEQUENCE OF (b) Brain Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION 4-24-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from April 21 , 19 68 , to April 26 19 68 , that (I) (we) last saw the deceased alive on April 26 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jaime Ambrad M.D. DEGREE <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED April 26, 1968			
22d. PHYSICIAN'S NAME (Type) JAIME AMBRAD, M.D.				22e. ADDRESS 7620 YORK RD. Towson, Maryland 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY Cathedral		23d. LOCATION (City or Town) (County) (State) Balto.			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd-12				25a. REC'D BY REGISTRAR DATE APR 30 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15
30M REV 1-68

DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

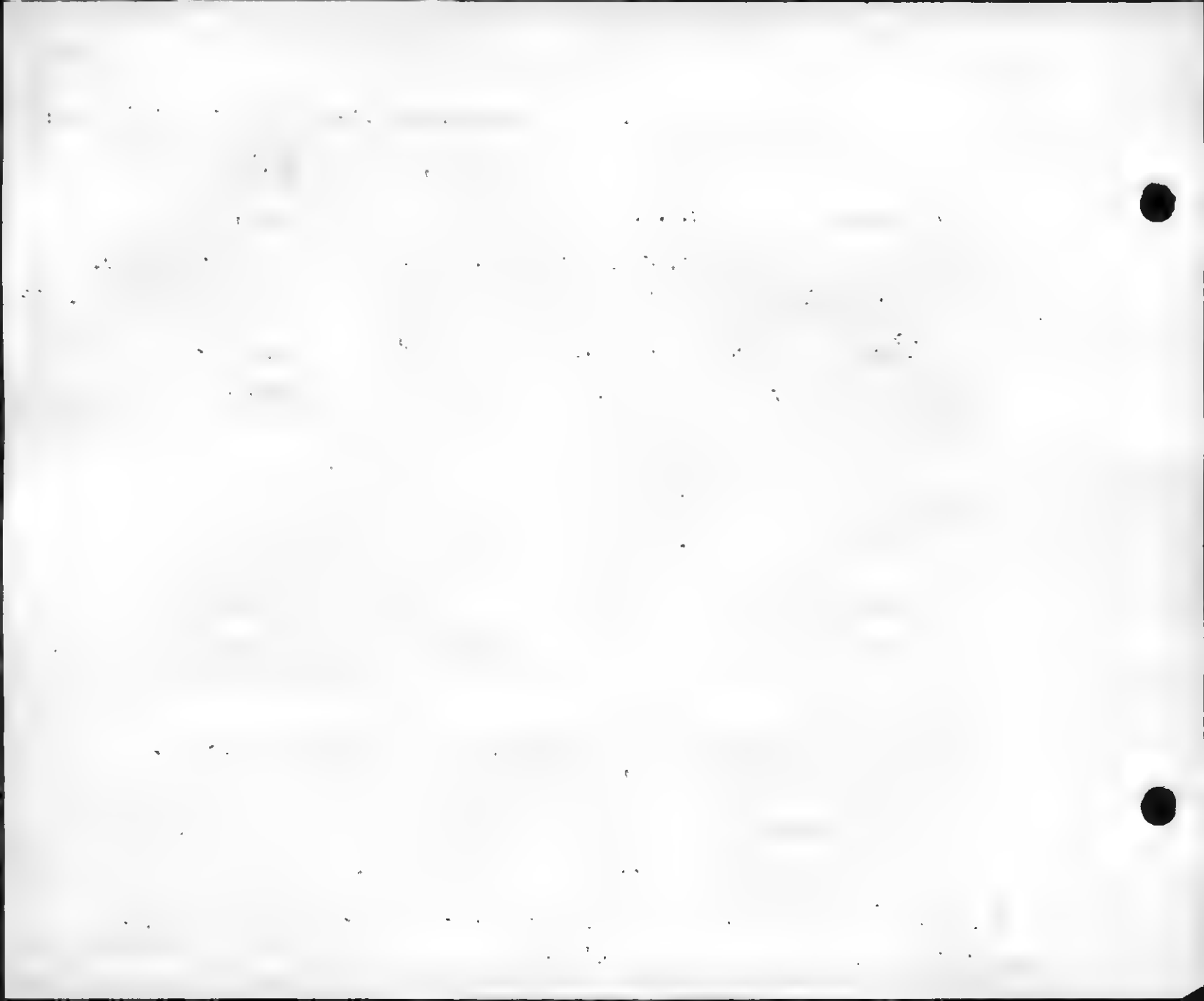
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
EDWARD L. MOULDS Sr.					Month 4 Day 5 Year 68 11:15A M				
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE		9/10/94		73 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
MARYLAND	U.S.A.				BALTIMORE COUNTY,		TRANSIT CO.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
FORT HOWARD		VET. ADM. HOSPITAL		BUS DRIVER					
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				1905 E. Ramblewood Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last James Moulds			First Middle Last Margaret Martin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
YES		213 10 15 98		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 INFARCTION OF MYOCARDIUM WITH HEART BLOCK									
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CORONARY THROMBOSIS									
DUE TO, OR AS A CONSEQUENCE OF (c) 4201									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital), attended the deceased from 2/21/68, 19, to 4/5/68, 19, that (a) (we) last saw the deceased alive on 4/5/68, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>John D. Talbert, MD</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>								22c. DATE SIGNED 4/5/68	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.								22e. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4-8-1968		OAK LAWN CEMETERY		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
LILLY & ZEILER FUNERAL EASTERN AVE. & WOLF STS. BALTIMORE, MD.				APR 9 1968		<i>Charles Judge</i>			

Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

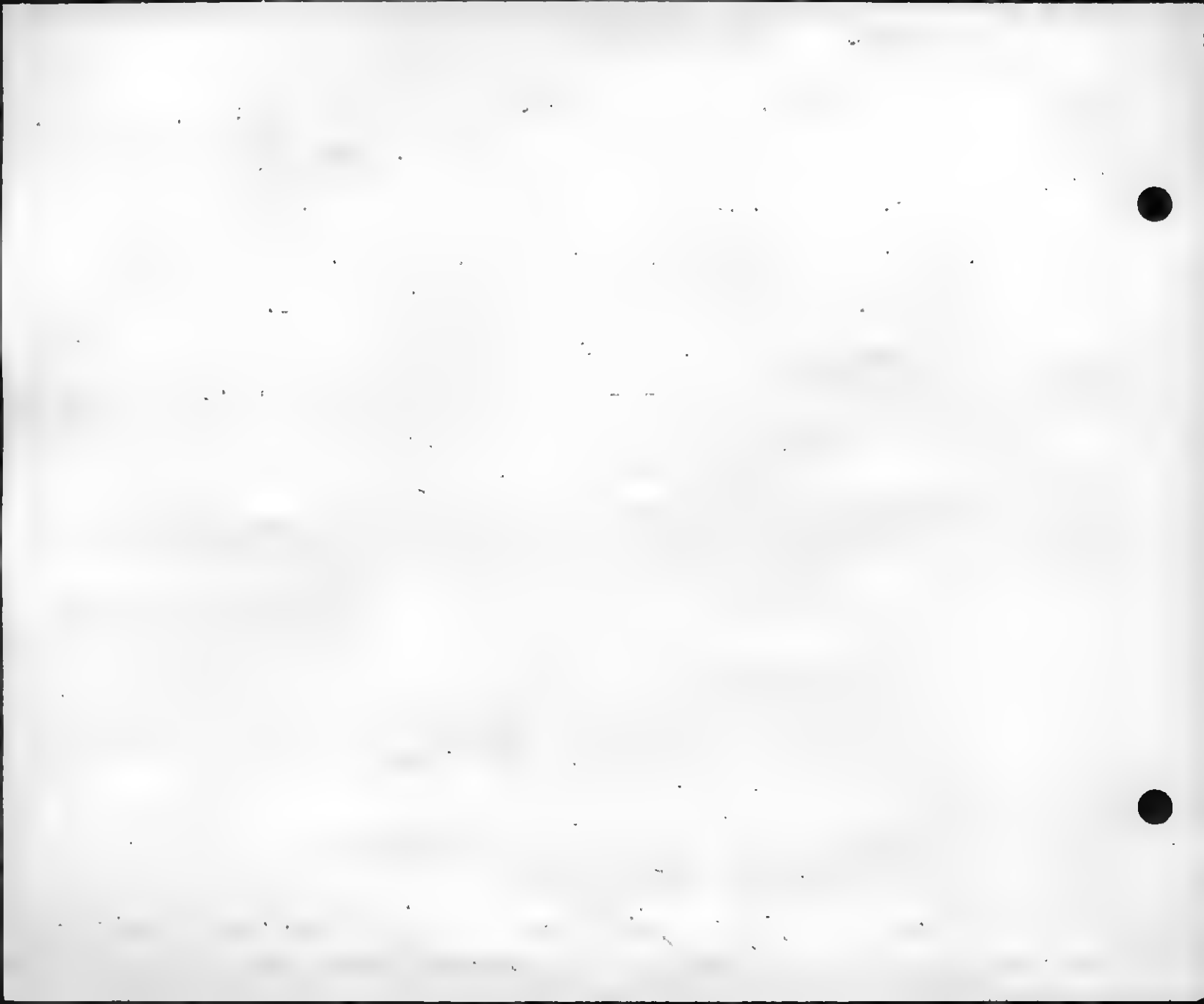
<div style="display: flex; justify-content: space-between;"> 05322 MARYLAND STATE DEPARTMENT OF HEALTH 05324 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>													
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JAMES J. MULHERAN, SR.				APRIL 22		1968		10:25					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		JULY 28, 1894		73 YRS		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
WEST VIRGINIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE, Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
TOWSON		ST. JOSEPH HOSPITAL		SHIPPING DEPT.		BETH. STEEL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
MARYLAND		BALTIMORE		DUNDALK				3424 SOLLERS POINT RD. #22					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
GEORGIE MULHERAN				NORA MCDONALD									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)				16b. SOCIAL SECURITY NO				17. INFORMANT					
YES WW II 13-09-0517				JANE MCG. MULHERAN				# 15					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Heart failure													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Pulmonary fibrosis													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Emphysema													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work													
22a. I certify that (I) (this hospital) attended the deceased from APRIL 22, 1968, to April 22, 1968, that (I) (we) last saw the deceased alive on APRIL 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								22c. DATE SIGNED					
Jose Nepomuceno, M.D.								April 23, 1968					
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
Jose Nepomuceno, M.D.								7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL		4/25/1968		BALTIMORE, NATIONAL				BALTIMORE, MD					
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. Brooks Bradley, Dundalk, Md.								APR 25 1968		J. J. J. J.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Clarence			B. Mumford			Month Day Year April 20, 1968		9:15 p. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
male		white		April 17, 1884		84 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Md.		U. S.				Baltimore		Md. FISH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			fisherman		FISH		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Cecil		Chesapeake		YES		none	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Benjamin MUMFORD			First Middle Last Mary E. NO INFO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address				
No			215-30-4505			Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>										
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS CVD</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (s) (this hospital) attended the deceased from May 6, 1964, to April 19, 1968, that (I) (we) last saw the deceased alive on April 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert Fisher M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 4/20/68				
22d. PHYSICIAN'S NAME (Type) Robert Fisher M.D.						22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4-25-68		BETHEL		CHESAPEAKE CITY, CEIL MD.				
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME ELKTON, MD						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
						DATE APR 24 1968		Charles Judge		



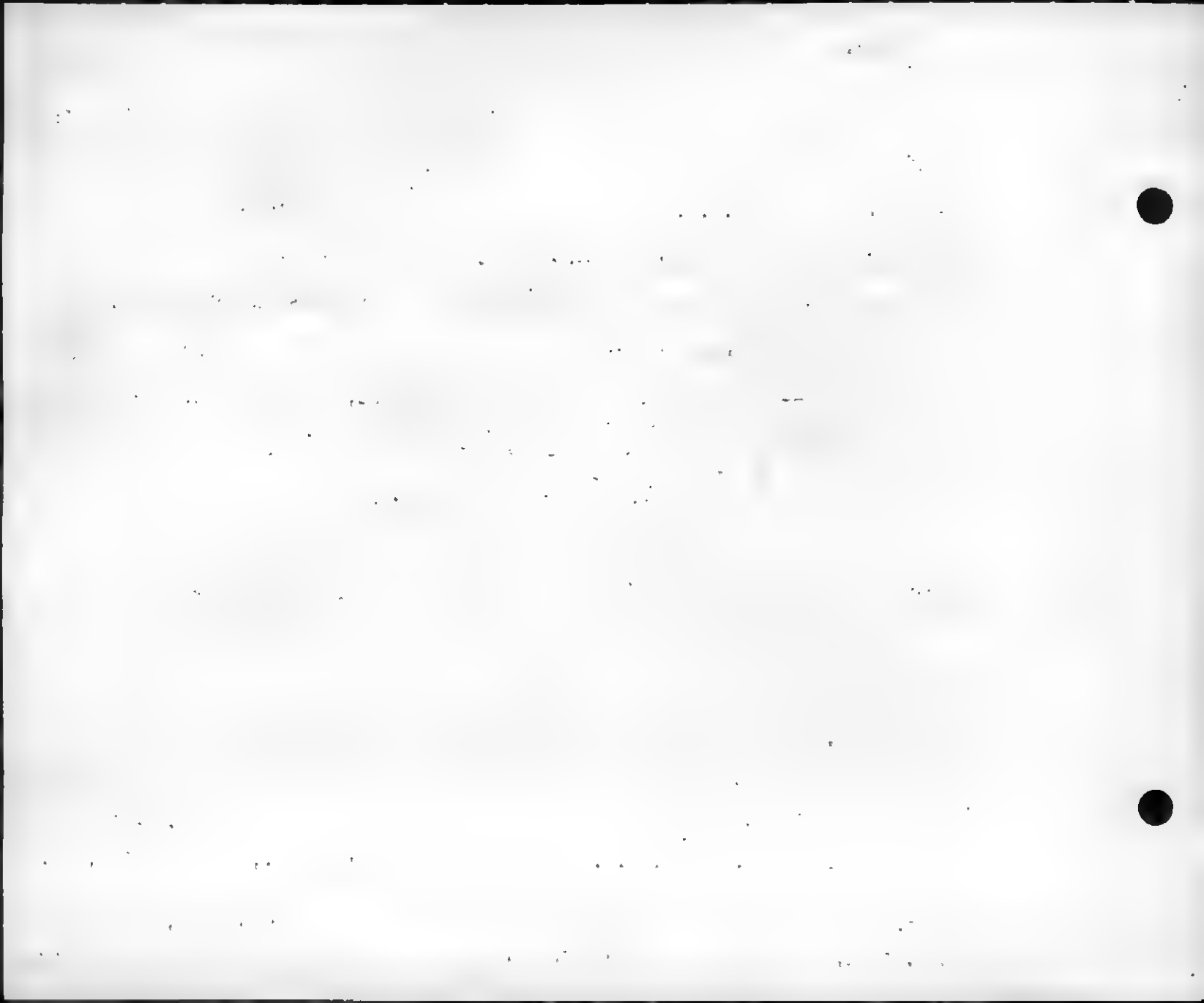
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 N
30M REV. 1/68

MD 224
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Michele Lee NEHRKORN			2a. DATE OF DEATH Month 4 Day 22 Year 68			2b. HOUR 5:35 P M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH 3/30/60		6. AGE (In years last birthday) 8 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Rosewood State Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent		12b KIND OF BUSINESS OR INDUSTRY none			
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 6745 Roberts Avenue	
14 FATHER'S NAME First Robert Middle Leroy Last Nehrkorn			15. MOTHER'S MAIDEN NAME First Barbara Middle Bernice Last Bright						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) --		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stelecrosis Cerebral Marked 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 345x (b) Cerebral insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks 7 yrs.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Excephalopathy due to postnatal Cerebral infection									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (1) this hospital attended the deceased from 6/2 , 19 66 , to 4/22 , 19 68 , that (1) (we) last saw the deceased alive on 4/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (and) (do not) view the body after death.									
22b. SIGNATURE Richard A. Jones		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/23/68					
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22e. ADDRESS Rosewood State Hosp., Owings Mills, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/68		23c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS 		25a. REC'D BY REGISTRAR DATE APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

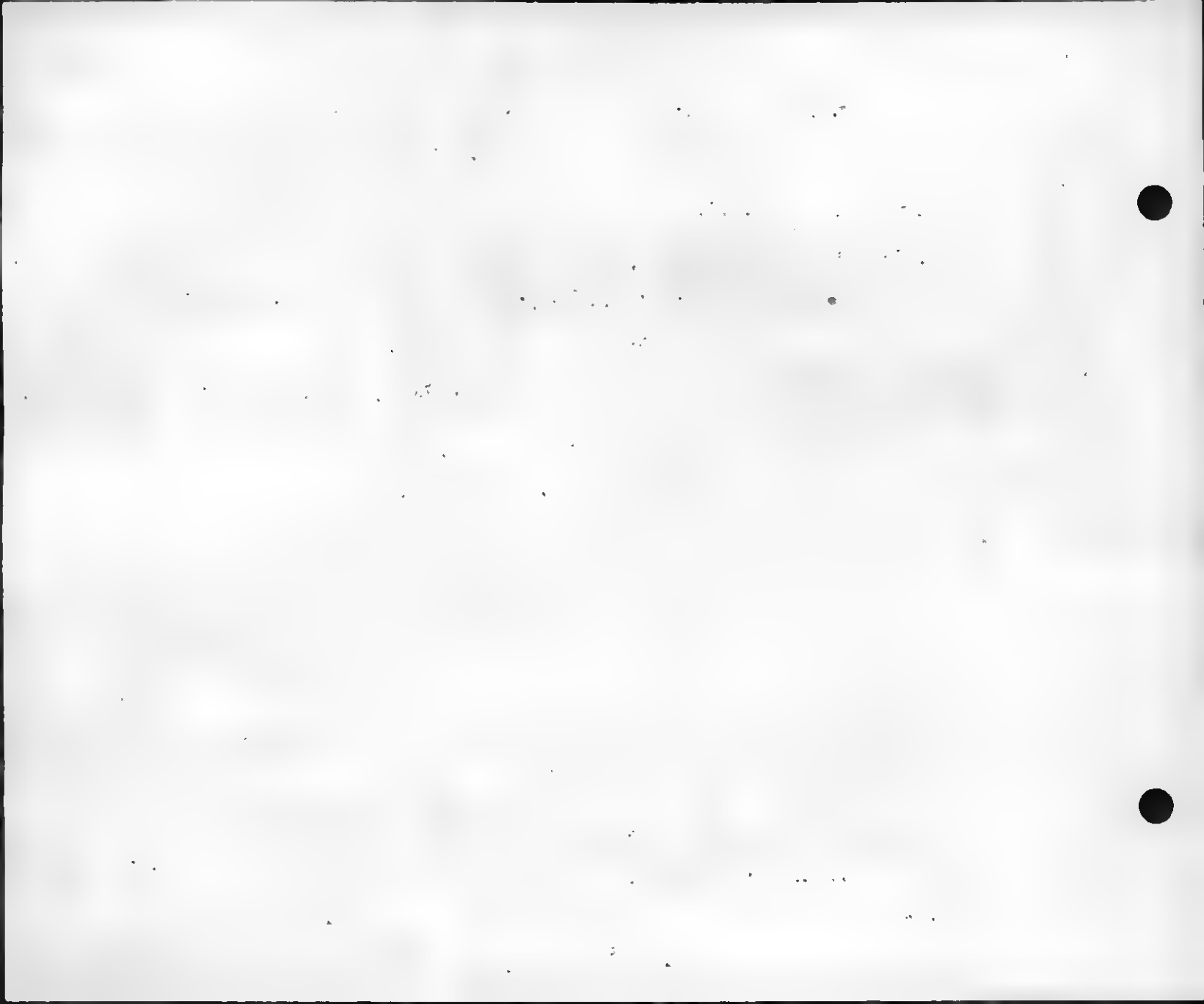


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VR A15 (4)
30M REV 1/68

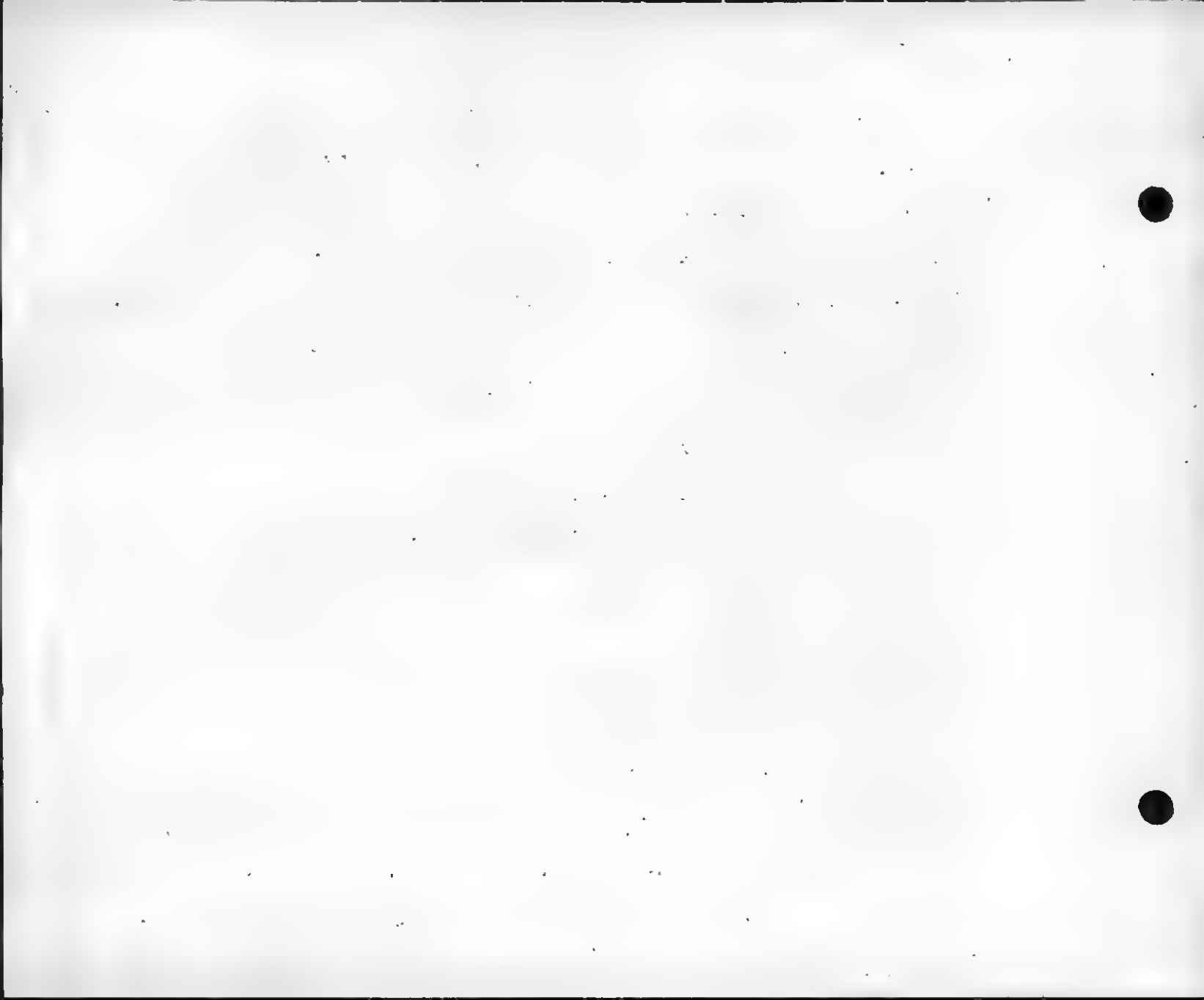
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) LEO ROBERT NESS			First Middle Last			2c. DATE OF DEATH Month April Day 24 Year 1968			2b. HOUR 11:45 AM
3 SEX Male		4. RACE White		5. DATE OF BIRTH May 22 1917			6 AGE (In years lost birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10 CITY OR TOWN OF DEATH Fort Howard		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Public Trasp.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 241 Main Street	
14. FATHER'S NAME First Jacob Middle B. Last Ness			15. MOTHER'S MAIDEN NAME First Agnes Middle Walsh Last Walsh						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give major dates of service) WW-11		16b. SOCIAL SECURITY NO. 214 12 07 99		17 INFORMANT Address Clinical Rcds, VA Hospital, Fort Howard, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLI t d 7 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 18, 1968 , to April 24, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. D. Talbert, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED 4/24/68			
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.						22e. ADDRESS VA Hospital, Fort Howard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 27, 68		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City or Town) (County) (State) Reisterstown, Maryland			
24. FUNERAL DIRECTOR ADDRESS Eline Funeral Home Reisterstown, Maryland						25a. RECD BY REGISTRAR APR 26 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	



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<div>00326</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Items 5 & 6 Film G399 4/22/68 kk CERTIFICATE OF DEATH</div>																							
1. DECEASED NAME (Type or print)			First Thelma			Middle Lillian			Last Neukam			2a. DATE OF DEATH Month April			Day 6			Year 1968			2b. HOUR 10:10		
3. SEX Female			4. RACE White			5. DATE OF BIRTH March 14, 1907			6. AGE (In years last birthday) 61 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md														
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2621 Mayfield Ave. 21213											
14. FATHER'S NAME First Harry V. Baker						15. MOTHER'S MAIDEN NAME First Lillian Harris																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT George Neukam, husband, above																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adynamic ileus DUE TO, OR AS A CONSEQUENCE OF (b) Pelvic abscess DUE TO, OR AS A CONSEQUENCE OF (c) Perforated urinary bladder												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that he (this hospital) attended the deceased from April 1, 1968, to April 6, 1968, that he (we) last saw the deceased alive on April 6, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above by (we) (did) not view the body after death.																							
22b. SIGNATURE <i>Reynaldo Orjuela-Gomez, M.D.</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>												22c. DATE SIGNED 4/7/68											
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.			22e. ADDRESS 7620 York Rd.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/10/68			23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.														
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane												25a. REC'D BY REGISTRAR DATE APR 10 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

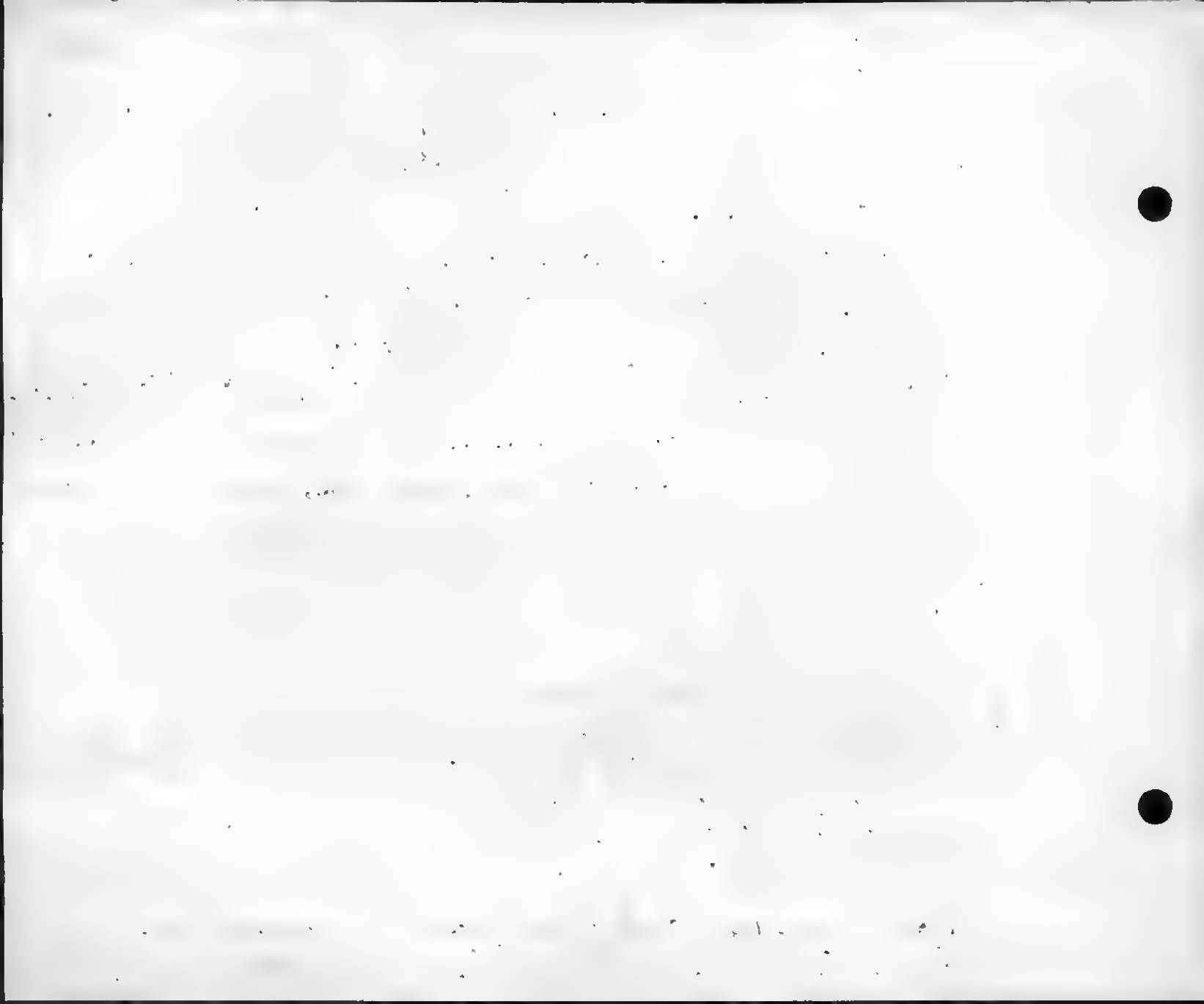


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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
Robert I. Nevitt						April 15, 1968		6:30 a.m.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
male		white		Feb. 29, 1893		75 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U. S.				Baltimore				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			clerk		real estate		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			Montgomery		Takoma Pk.		YES		30 Elm Street	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
Robert I. Nevitt				Annie Schribner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT				
Yes				17-791-563		Marion G. Nevitt, 10820 Ga. Ave. S.S.Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				Ruptured aneurysm of the abdominal aorta						
441.2				DUE TO, OR AS A CONSEQUENCE OF						
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost				(b) Arteriosclerosis, generalized, senile						
				DUE TO, OR AS A CONSEQUENCE OF						
				(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No.		City or Town		County State		
22a I certify that (a) (this hospital) attended the deceased from Feb. 18, 1929, to April 15, 1968, that (x) (we) last saw the deceased alive on April 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE						22c DATE SIGNED				
Anthony J. Young, M.D.						4-16-68				
22d PHYSICIAN'S NAME (Type)						22e ADDRESS				
Anthony J. Young, M.D.						SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)				
Burial		Apr. 19, 1968		Rock Creek Cemetery		Washington, D. C.				
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
C. Glen Carter 843 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.						DATE		APR 22 1968		

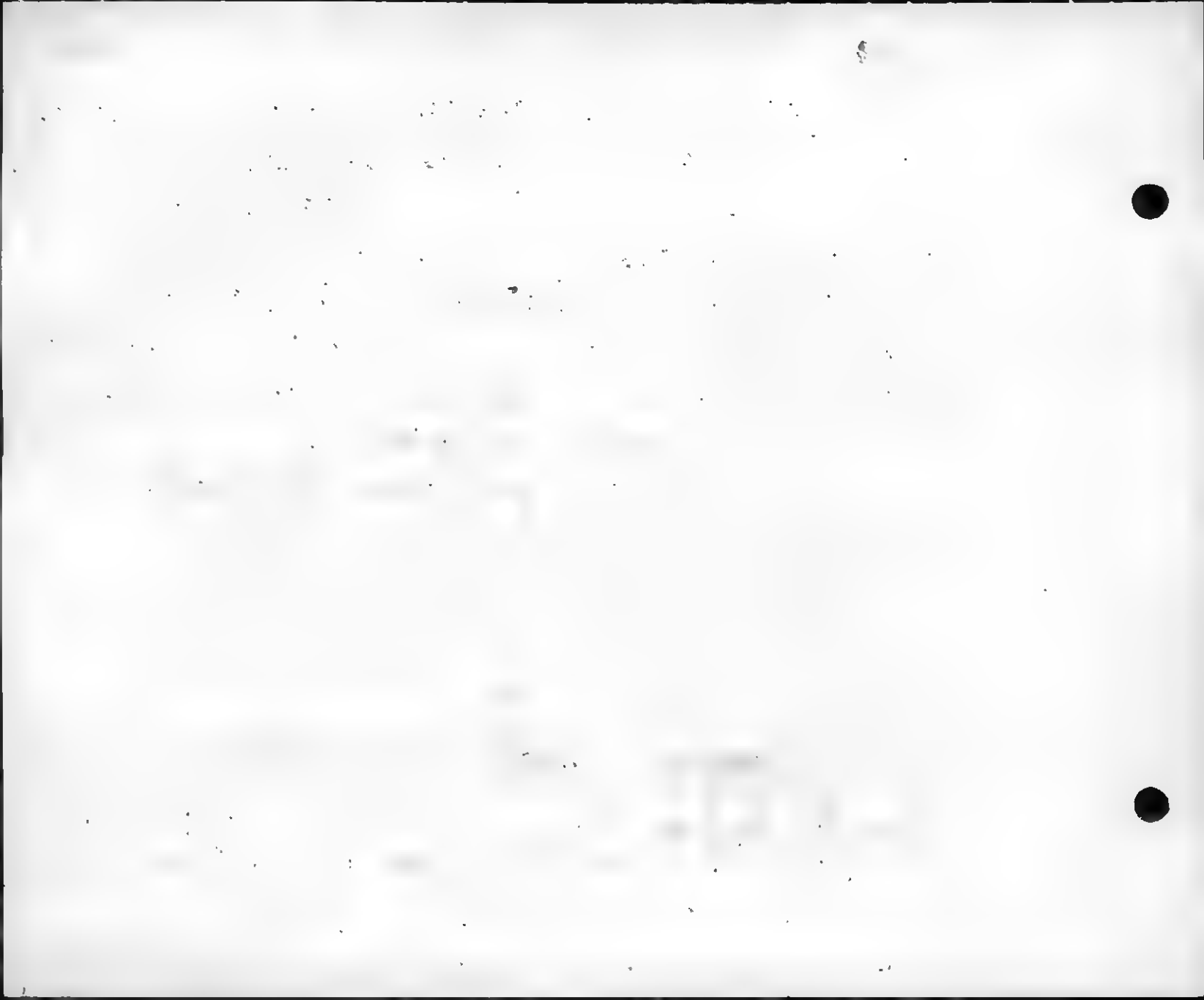


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MD 271
1
5328
MAY 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last LLOYD GORDON NEWTON			2a. DATE OF DEATH Month Day Year APRIL 26 1968		2b. HOUR 3:05 PM
3. SEX MALE	4. RACE CAU	5. DATE OF BIRTH 7-22-1915		6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BUTCHER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 479 - Rt #16	
14. FATHER'S NAME First Middle Last EARL NEWTON		15. MOTHER'S MAIDEN NAME First Middle Last SALLY JONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO UNK.	17. INFORMANT Address CATHERINE NEWTON ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastasis? DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoepithelioma, Rt. tonsillar fossa DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from 4/25 , 19 68 , to 4/26 , 19 68 , that (1) (we) last saw the deceased alive 3:30 PM 4/26 , 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jose M. de Leon, MD		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/26/68	
22d. PHYSICIAN'S NAME (Type) JOSE M. DE LEON, MD		22e. ADDRESS GBHC 6701 D. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/29/68	23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION (City or Town) (County) (State) BALTO. MD	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MARY		25a. REC'D BY REGISTRAR DATE APR 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



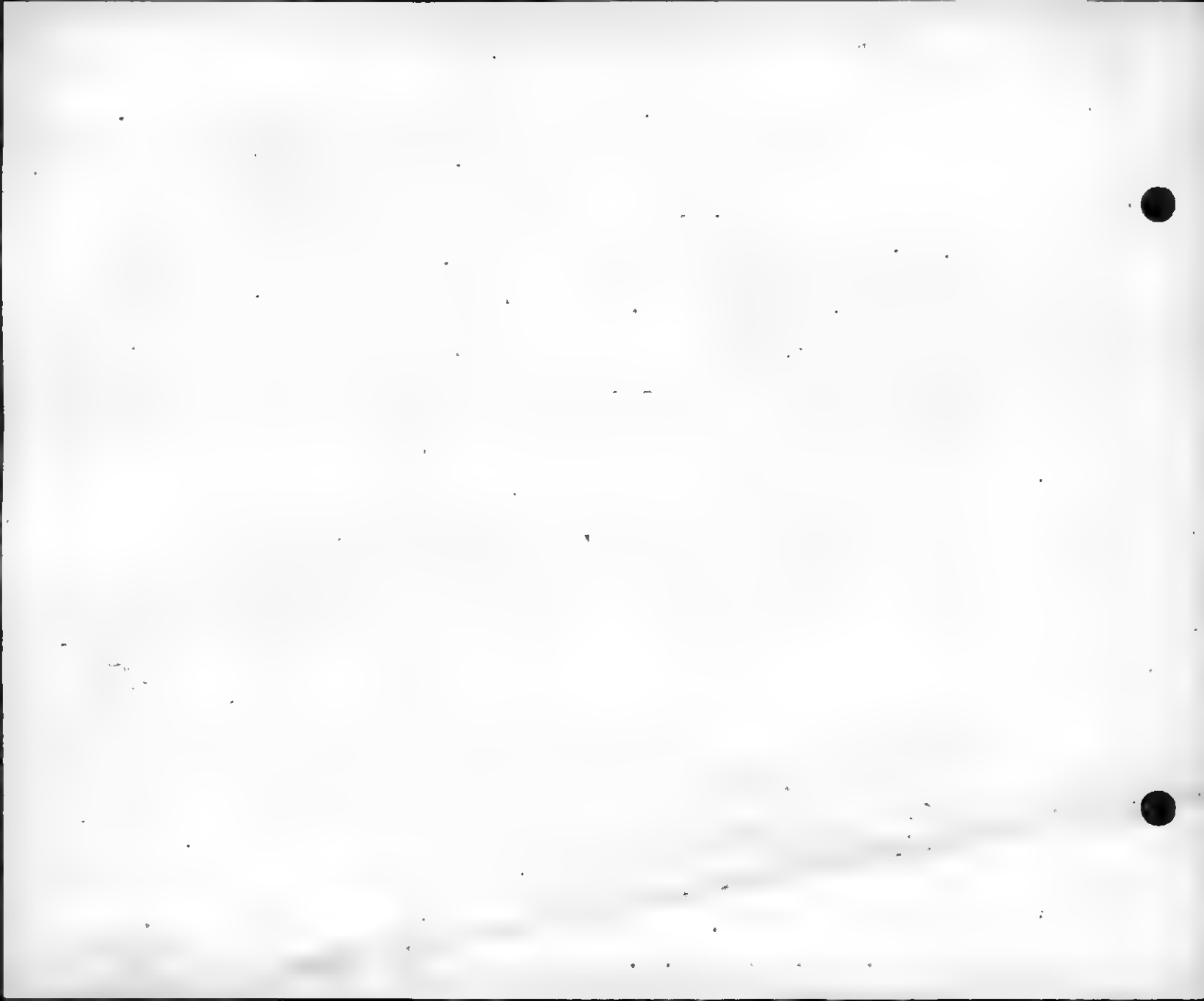
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-6
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR					
Anna		S.		Hollmeyer	April 15, 1968		M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
female		white		Jan. 16, 1875		93 YRS						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Germany		U. S.				Baltimore		Md.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY						
Catonsville		SPRING GROVE STATE HOSP.		housewife								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e. STREET AND NUMBER				
Md.		Balto.		Parkville				2908 Lingamore Avenue				
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last			
Peter Krich					Eva.				?			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address				
No				219-05-4870		Records: SPRING GROVE STATE HOSPITAL						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>AS CVD</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes Mellitus</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21a PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from 9-7, 1968, to 4-15, 1968, that (I) (we) last saw the deceased alive on 4-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Robert Fisher M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c DATE SIGNED 4/15-68		
22d PHYSICIAN'S NAME (Type) <u>Robert Fisher M.D.</u>										22e ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		4/18/68.		Holy Redeemer Cemetery		Baltimore, Md.						
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
Leonard J. Ruck, Inc. Balto. Md. 21214				APR 16 1968		Charles J. J. J.						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		First SOPHIE		Middle M.		Last O'BRIEN		2a. DATE OF DEATH April Month 7 Day 1968		2b. HOUR 11:00A.	
3. SEX Female		4 RACE White		5. DATE OF BIRTH March 2, 1885		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in the Pines				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY House Work			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY Baltimore		13c. CITY OR TOWN Eastwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 423 Pembroke Blvd.			
14. FATHER'S NAME First Middle Last ? Chimniak				15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO None		17. INFORMANT Address Paul W. O'Brien: 423 Pembroke Blvd. Ba. Co.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Valvular Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Arteriosclerotic C.-V. Disease</u> (And trans. if any, which gave rise to immediate cause (a), stating the underlying cause last.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks. 30 yrs. 20 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from <u>2-2-1968</u> , to <u>4-7-1968</u> , that (1) (we) last saw the deceased alive on <u>4-5-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Wilmer K. Gallagher, Sr. M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>								22c. DATE SIGNED <u>4/8/68</u>			
22d. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr.		22e. ADDRESS 6209 Frederick Ave. Balto., 21228, Md.									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4-10-68.		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) 4300 Frederick Ave. Balto., Md.					
24. FUNERAL DIRECTOR <u>Charles S. Zeiler</u>		ADDRESS 6224 Eastern Ave. Baltimore, 21224, Md.				25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE <u>John C. Judge</u>			

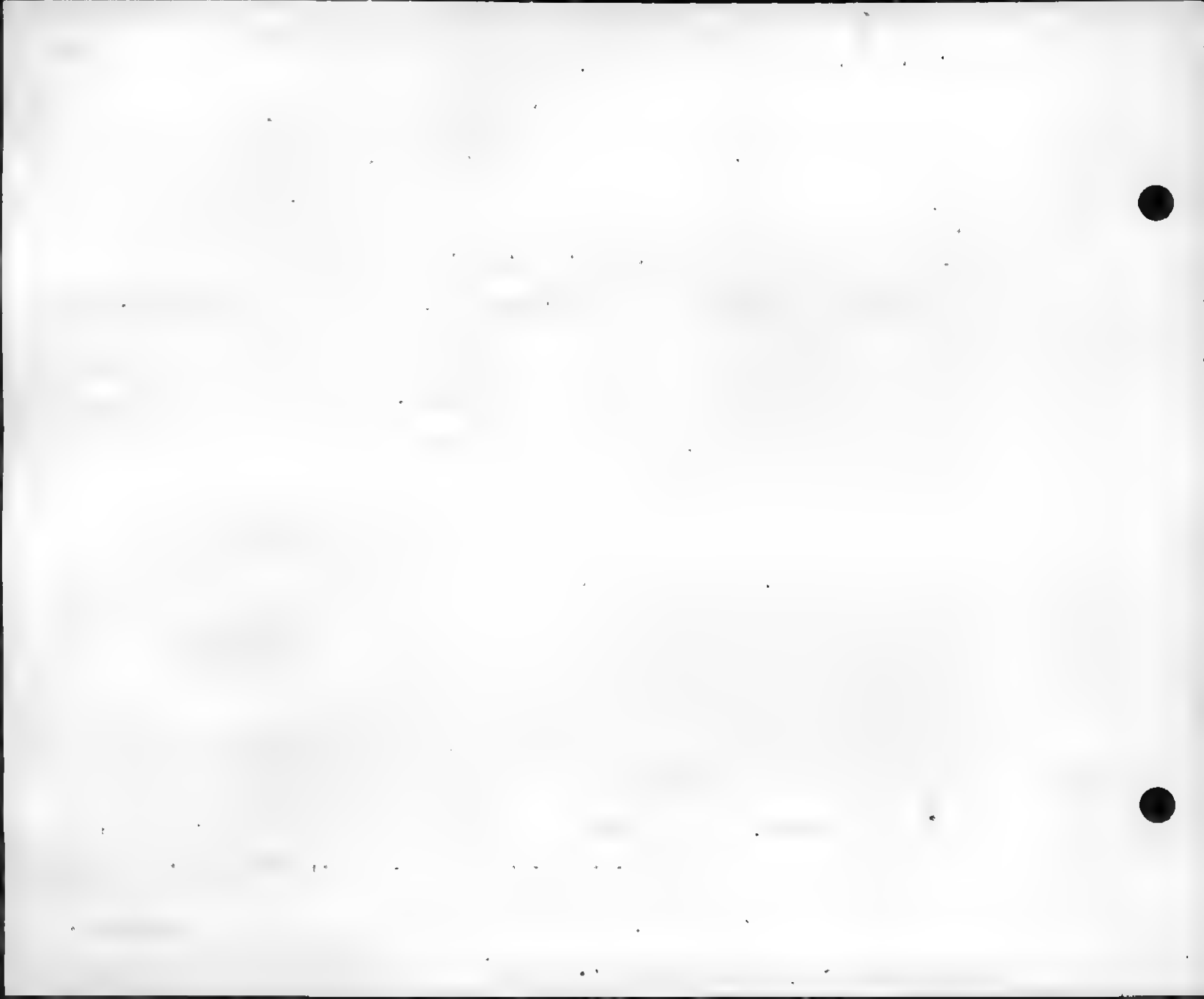


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (whether original or copy), page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
<div>15332</div> <div>Released by Medical Examiner</div> <div>CERTIFICATE OF DEATH</div>													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M				
CARRIE			O'CONNOR			April 21 1968			2:00 M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		7. UNDER 24 HRS		
Female		White		September 10, 1888			79 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland			U.S.A.						Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			St. Joseph Hospital			Homemaker							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			(Baltimore)			Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>			8112 Woodhaven Rd. 21206	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Unknown Walden			Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			21206				
			214-03-4066			Dr. Denzel D. Martin 4603 Powell Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage													
4017 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 331X DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Possible subdural hematoma													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cert exam net)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1968, to April 21, 1968, that (I) (we) last saw the deceased alive on April 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE			22c. DATE SIGNED			22d. ADDRESS							
Paglinawan, Jr.			April 21, 1968			7620 York Rd., Towson, Md. 21204							
22e. PHYSICIAN'S NAME (Type)			22f. ADDRESS										
Teodulo Paglinawan, Jr. M.D.			7620 York Rd., Towson, Md. 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			4-24-1968			Mt. Carmel Cemetery			Baltimore Co. Md.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Funeral Home 7401 Brien Road			DATE APR 24 1968			Charles Judge							

MEDICAL CERTIFICATION



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VR A-10
304 REV 1-58

MD3332

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
WILLIAM		14.	OGLE	APRIL	Month 12 Day 1968	2:55 P.M.
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
M	W	JAN. 2, 1888		80 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
			BALTIMORE Md.			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE, MD.	SHANGRI-LA N.Y.		PAINTER-RET.	SELF-EMP.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
MD.	BARO.	CATONSVILLE		2207 OLD FREDERICK RD.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	
JOSEPH			OGLE		ANNA WAGNER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
No				Mrs. L. W. Schmitt 2207 Old Frederick		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						24 days
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalized						10 years
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
Chronic congestive heart failure ② Adenocarcinoma, bladder						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (we) attended the deceased from Nov. 17, 1947, to April 12, 1968, that (I) (we) last saw the deceased alive on April 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
GILBERT E. RUDMAN						4/13/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
GILBERT E. RUDMAN, M.D.		2517 W. BALTO-ST.				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial	4-15-68	Lutheran Trk Cem.		Baltimore Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
J. W. C. C. J. W. C. J. W. C.		Catonville, Md.		DATE APR 18 1968		Charles Judge

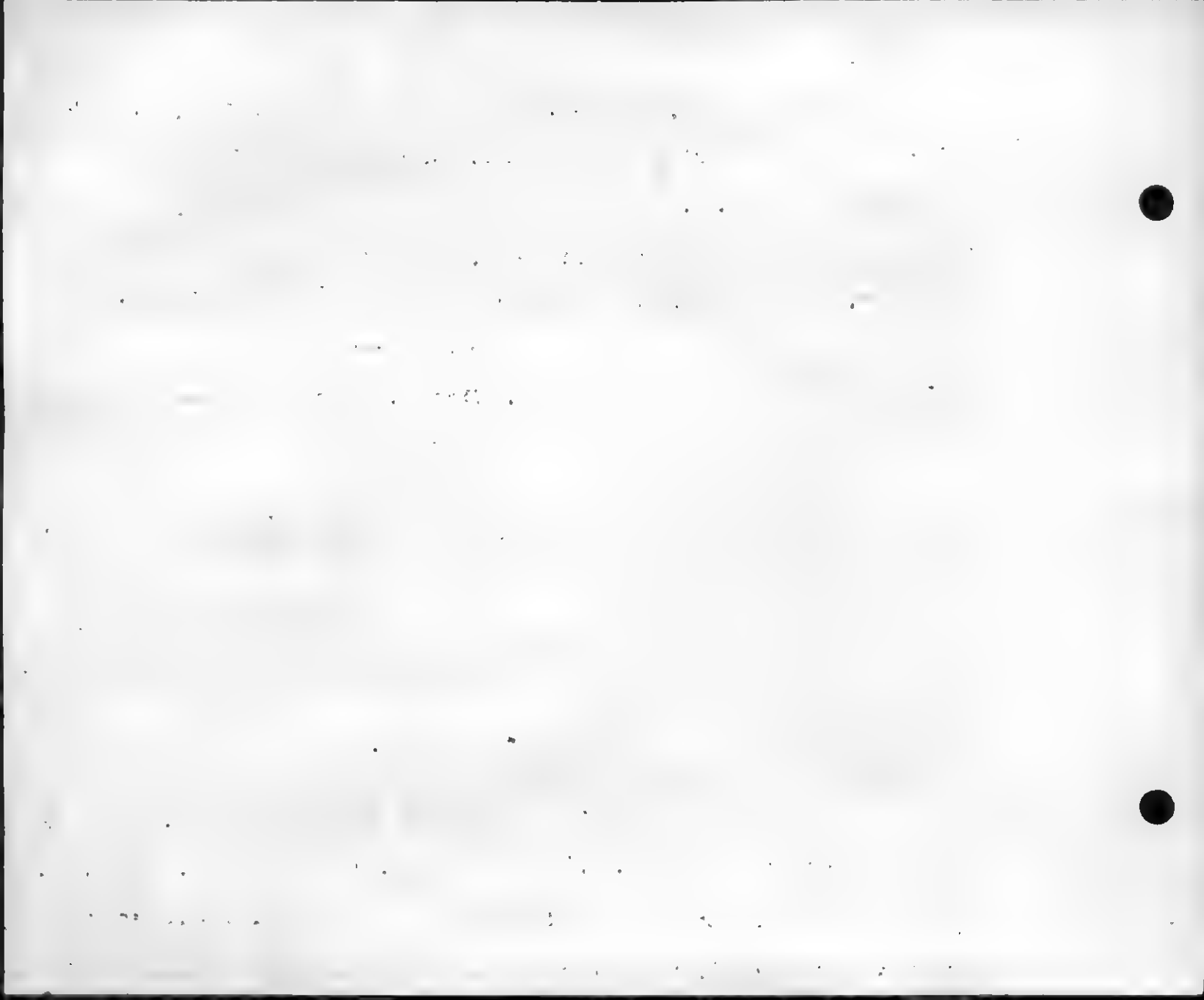


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VR A15 (4)
3044 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First ANN			Middle F. OHLENDORF			Last			2a. DATE OF DEATH Month April Day 29 Year 1968		2b. HOUR 4:30 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Dec. 13, 1902				6. AGE (In years last birthday) 65 YRS.		IF UNDER YEAR MONTHS 05 DAYS 00		IF UNDER 24 HRS HOURS 00 MIN 00			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Co. Md									
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor Conv. Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Stoneleigh		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 714 Stoneleigh Rd.							
14. FATHER'S NAME First Annie Middle Schermeyer Last				15. MOTHER'S MAIDEN NAME First Annie Middle Schermeyer Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. Albert V. Ohlendorf				Address Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Recent CA 2 DUE TO, OR AS A CONSEQUENCE OF (c) brain metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from April 27, 1968 to April 27, 1968 , that (I) (we) last saw the deceased alive on April 27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE R. K. Gundry								DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 30, 1968			
22d. PHYSICIAN'S NAME (Type) Richard Gundry M. D.				22e. ADDRESS 2 W. University Pkwy. Balto. Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Co., Maryland									
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy. (21225)				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

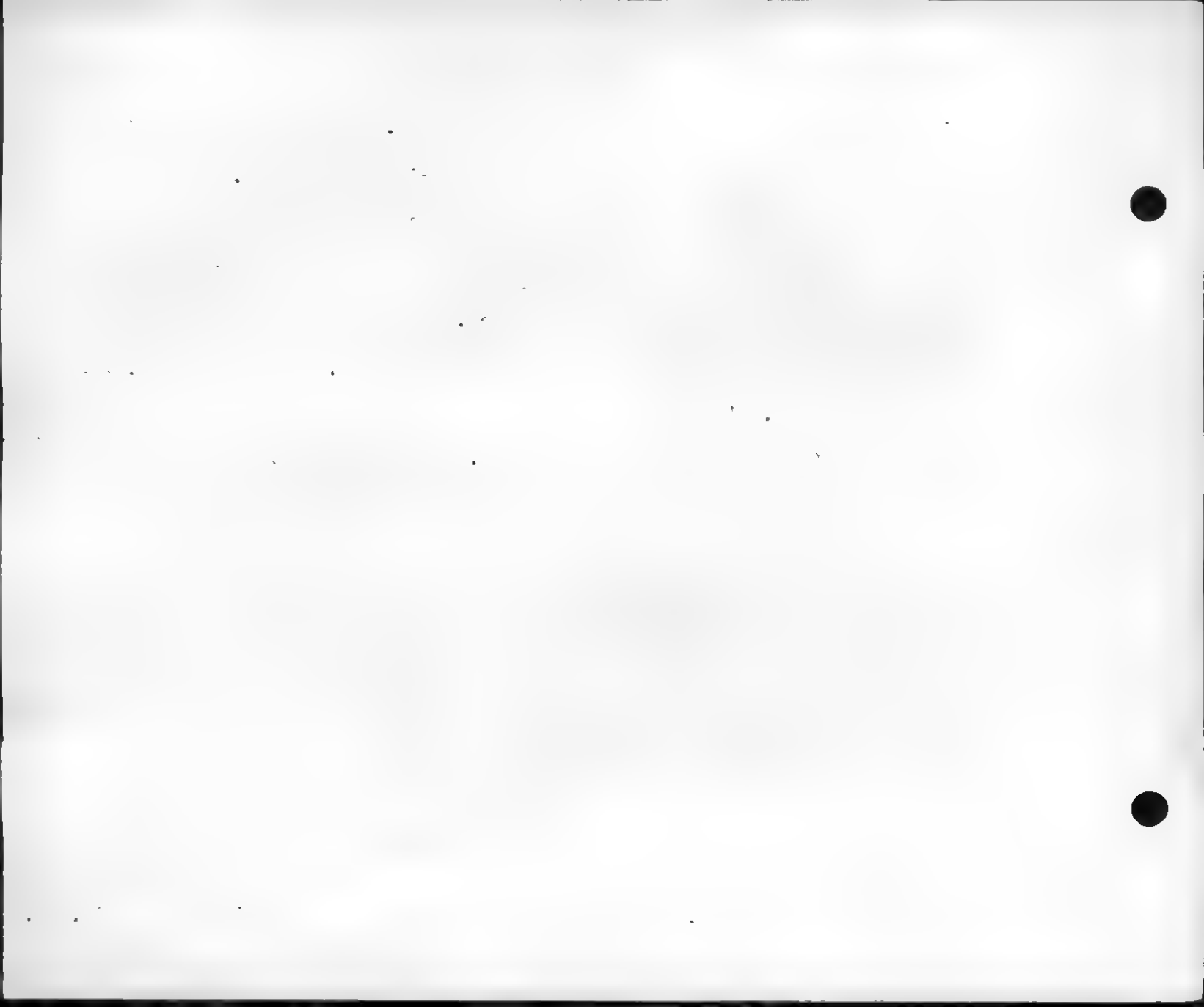
CERTIFICATE OF DEATH

336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

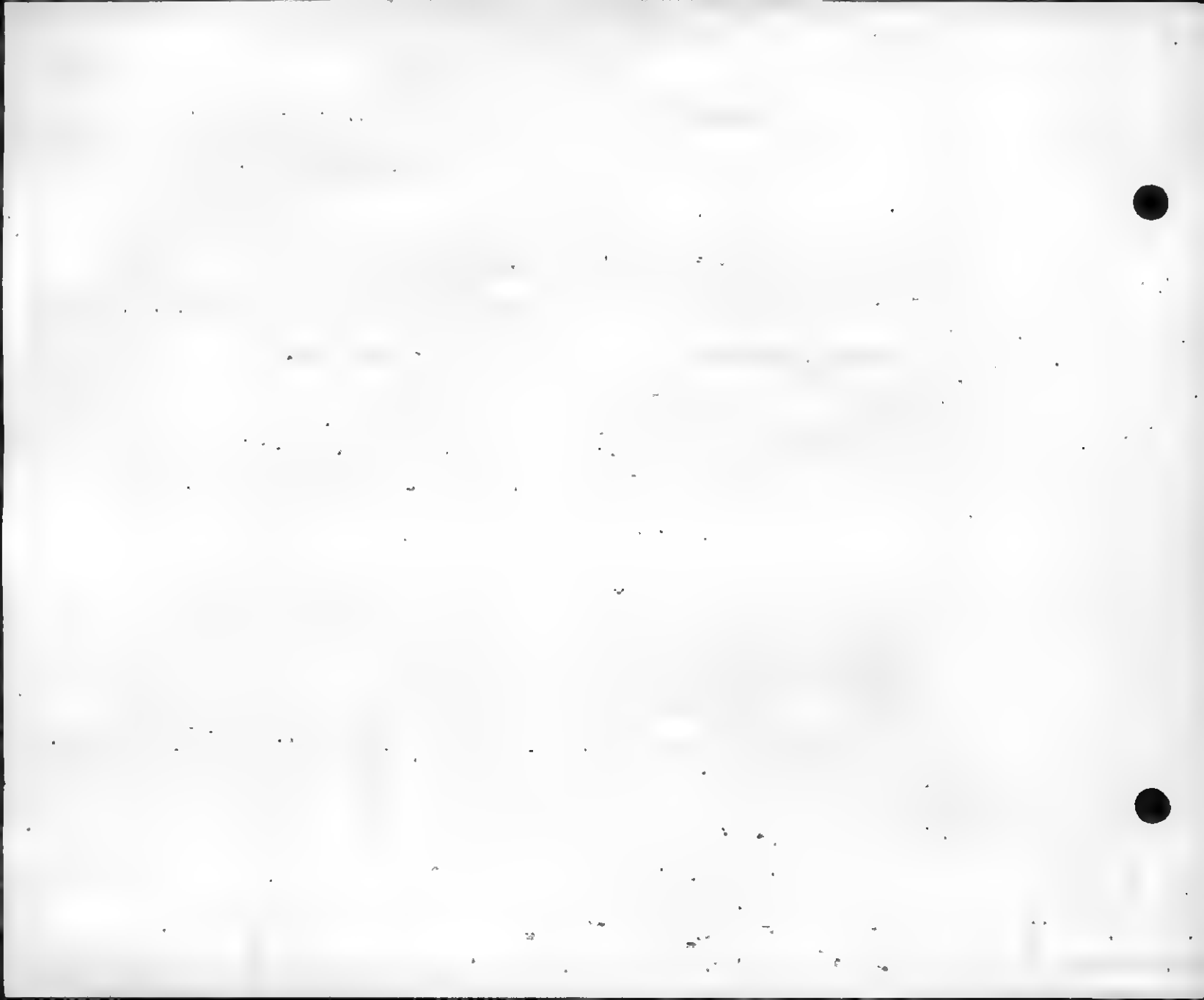
1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Baltimore</u>			
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville, Md.</u>			
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Robbs Nursing Home</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Angela O'Neill</u>				4 DATE OF DEATH Month Day Year <u>April 27, 1968</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct. 2, 1882</u>	9 AGE (In years last birthday) <u>85</u> yrs.	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>		10b KIND OF BUSINESS OR INDUSTRY <u>tailor</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thomas A. O'Neill</u>				14 MOTHER'S MAIDEN NAME <u>Rebecca Bloss</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>216-329389</u>		17 INFORMANT Address <u>Pikesville, Md.</u> <u>Mrs. Margaret Mossel, 205 1/2 Church Lane</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary vascular accident with left bundle branch block</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>331x</u> (c) _____ DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease, temporal arteritis</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 1968		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec., 1958</u> , to <u>28 Apr., 1968</u> , that (I) (we) lost the deceased alive on <u>26 Apr. 1968</u> , and that death occurred at <u>1 A.M.</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Paul H Royse</u>				22b DATE SIGNED <u>30 Apr 68</u>		22c PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>	
22d ADDRESS <u>1423 today La Pikesville Rd.</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b DATE THEREOF <u>May 1, 1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Pikesville Baltimore, Md.</u>	
24 FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville</u>				25a REC'D BY REGISTRAR DATE <u>MAY 7 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Lela Elizabeth Ott						Month Day Year			9:10 AM		
3 SEX			4. RACE			5 DATE OF BIRTH			6 AGE (n years last birthday)		
Female			White			May 26, 1898			69 YRS.		
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland			U.S.A.						Baltimore Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Towson			Greater Balto. Med. Center			Housewife			Home		
13a USLA. RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland						Baltimore			2802 Roselawn Ave 21214		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Joseph L. Lancaster			Catherine G. Fink								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
No			212-32-3452			Edward A. Ott			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) - <u>arteriosclerotic heart disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) - <u>coronary atherosclerosis</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) - <u>diabetes mellitus</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Diabetes mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1967, to April 25, 1968, that (I) (we) last saw the deceased alive on April 23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE			22c. DATE SIGNED								
Dr. Donald Mintzer			April 25 1968								
22d PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Dr. Donald Mintzer			3009 Evergreen Ave								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			4-29-68			Glen Haven			Glen Burnie, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Curtis E. Evans 1400 S. Charles St/ 21230			DATE APR 26 1968			f Charles Judge					



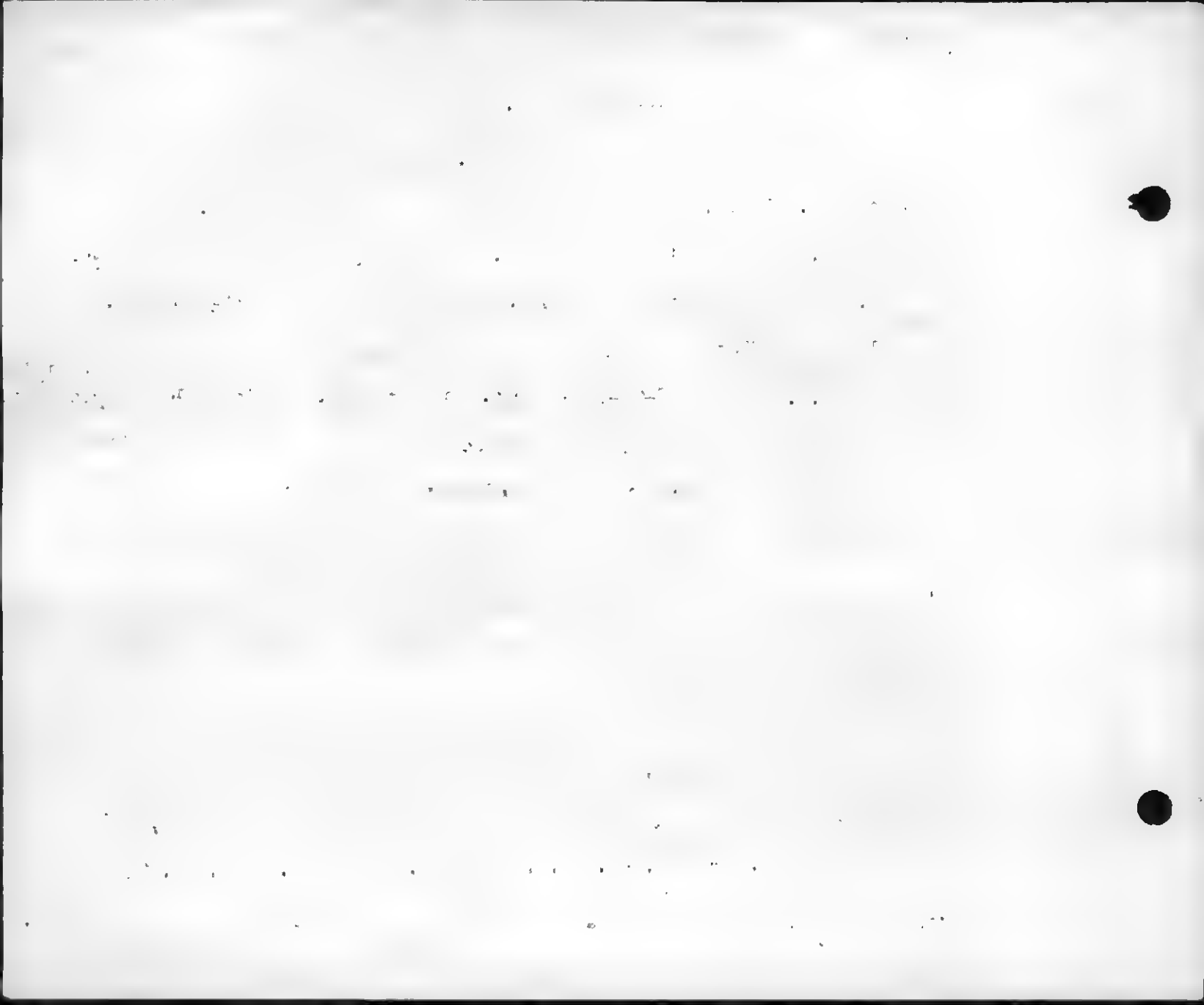
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Walter Hiblett Parrish			2a. DATE OF DEATH Month Day Year April 30 1968		2b. HOUR 11 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH Feb. 5, 1916		6. AGE (In years last birthday) 52 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co. Md.	
10 CITY OR TOWN OF DEATH Baltimore, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5710 Brighton Ave.		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Farm-Central
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore-15	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 6710 Brighton Ave.
14. FATHER'S NAME First Middle Last Walter Clem Parrish			15 MOTHER'S MAIDEN NAME First Middle Last Ethel Doyle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, oo, or unknown) (If yes give war or dates of service) Yes W.W. II		16b. SOCIAL SECURITY NO. 218-01-6523	17 INFORMANT Address Mrs. Roberta Oliff Parrish, 6710 Brighton Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) T.V.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 19 50 to April 30, 19 68, that (I) (we) lost saw the deceased alive on April 24, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Millard T. Traband, Jr.				22c. DATE SIGNED 3 May 1968	
22d. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M.D.				22e. ADDRESS 1811 N. Rolling Rd. Balt. Md. 21207	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 4, 1968	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Woodlawn Baltimore, Md.
24. FUNERAL DIRECTOR Frank H. Newell, Pikeville, Ky.			25a. REC'D BY REGISTRAR MAY 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

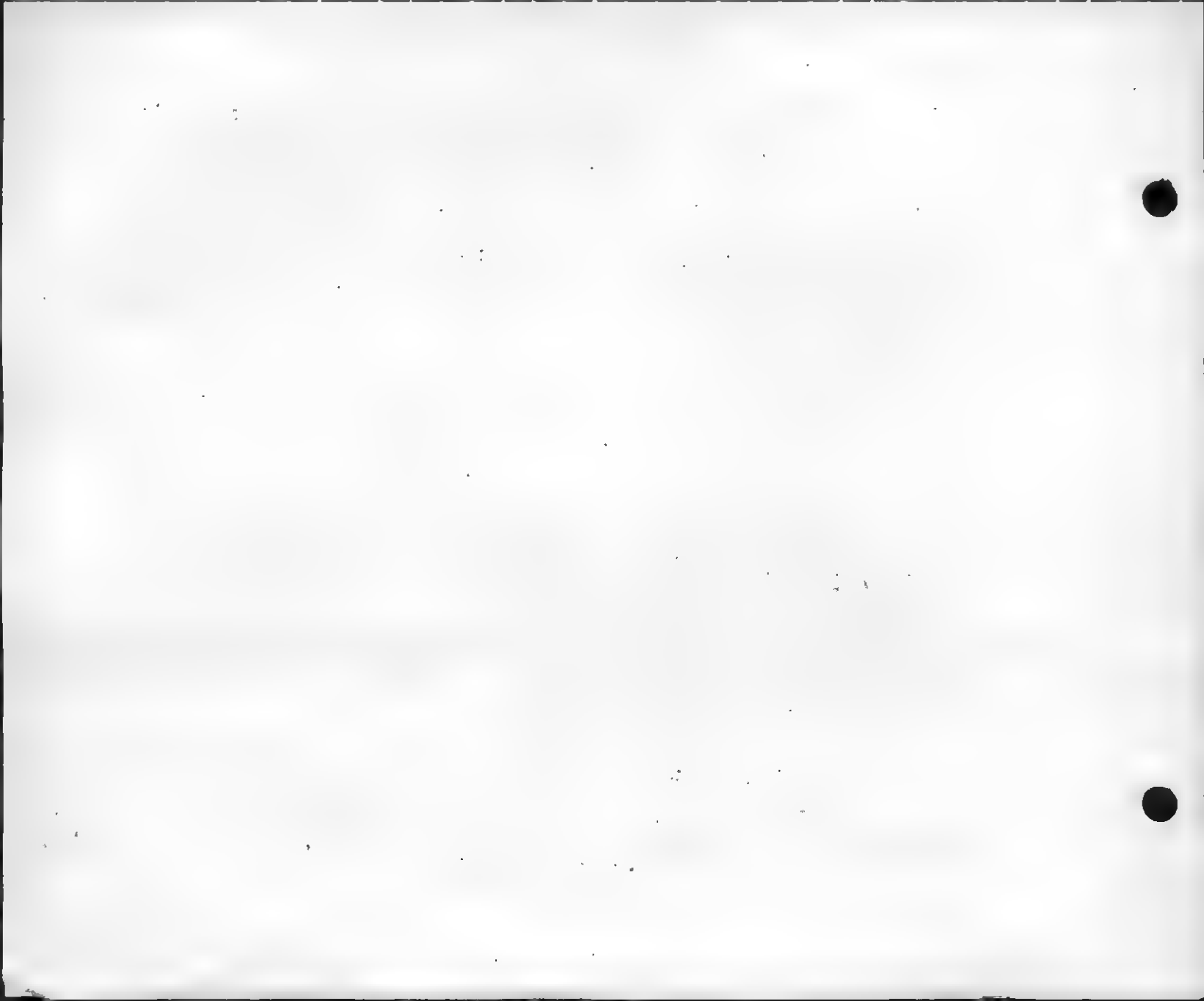


FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOJR		
LILLIAN E. PATRICK						4-20 1968			11-A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
F	W	10/23/1912	55 YRS					4-20-68		5:45 P M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
MD			USA						BALTO. Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
ESSEX			BOX GINWOOD LANE								
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MD			BALTO			ESSEX			BOX 77 GINWOOD LANE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
THOMAS JONES			MARIAN PILLING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			213-20-7091			CARL N. PATRICK SR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Diabetes Mellitus</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MEDICAL EXAMINER			22b. DATE SIGNED		
M.B. Davis			6800						4/20/68		
EXAMINER'S NAME (Type)			ADDRESS			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)		
M.B. DAVIS			MORNINGTOWN RD								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			4/23/68			PARKWOOD			BALTO. MD		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
J.G. CONNELLY SONS			300 MACE			APR 24 1968			Charles Judge		

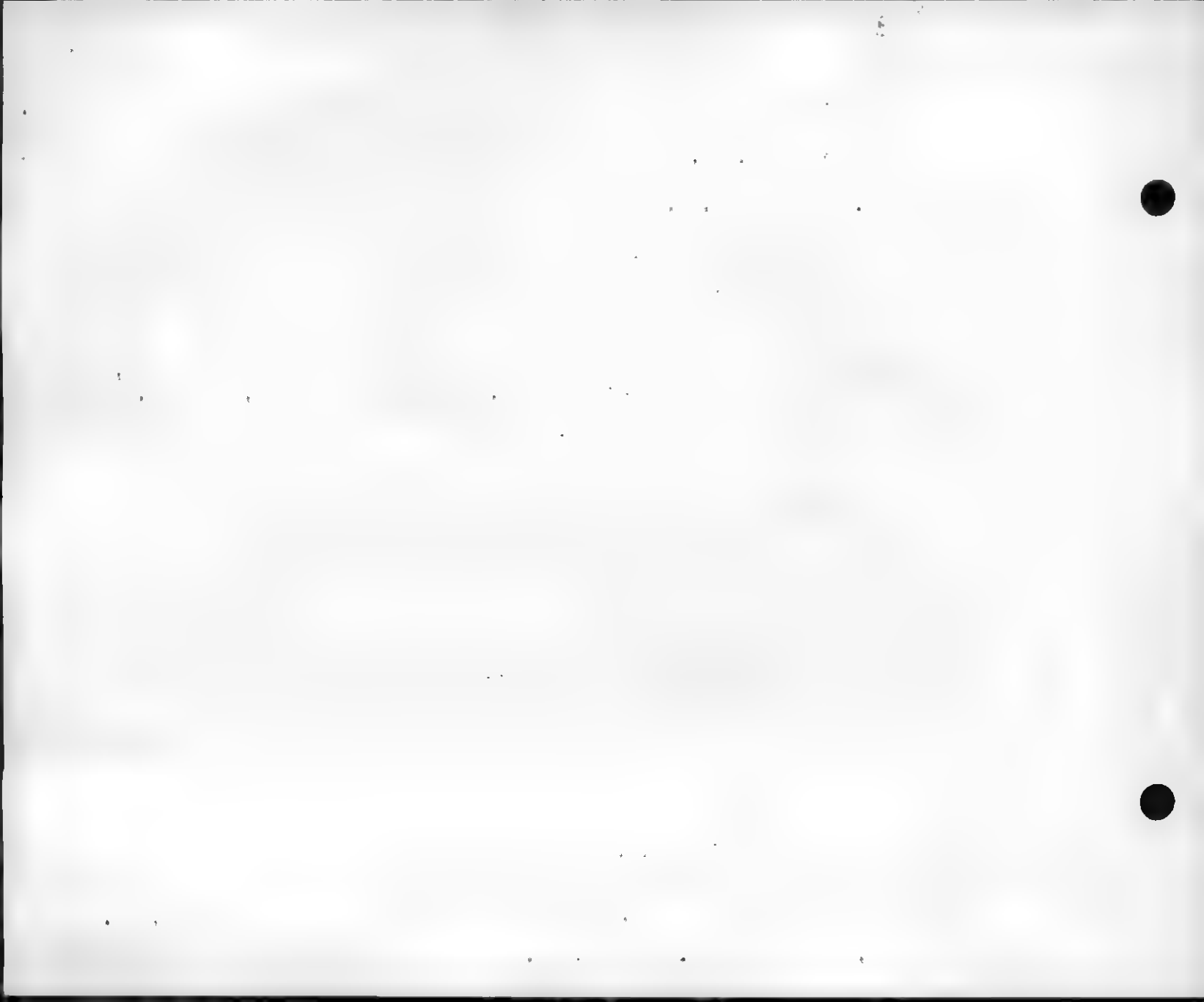


FOR STATE
HEALTH DEPT.

TO DEPUTY CLERICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <u>4/29/</u> <u>1968</u>	
ROY			GLENWOOD		PENNINGTON				2b. HOUR <u>1 A.M.</u>	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 MONTHS	8 DAYS	9 HOURS	10 MIN.	2c. DATE PRONOUNCED DEAD Month <u>April</u> Day <u>29</u> , Year <u>1968</u>		2d. HOUR <u>1 A.M.</u>
male	white	Aug. 31, 1924	43	YRS						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		
West Va.			U. S. A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Dundalk			7920 St. Gregory Drive			Mechanic			Bethlehem Steel	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore			Dundalk				7924 St. Geogoy Drive
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Stanford			Pennington		Pearl		Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Wife)			ADDRESS	
Yes			WWII			218-16-4411			Mrs. Rosemary Pennington, 7920 St. Gregory Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun Wound of Chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <u>12:10 A.M. 4/29 1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <u>Subject shot self in chest</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>home</u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u>Dundalk, Baltimore, Maryland</u>				
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED	
			Werner u. Spita, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			<u>4/29/68</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			5/2/68		St. Stanislaus Cemetery			Baltimore, Md.		
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
John J. Duda, 7922 Wise Ave. Dundalk, Md.								APR 30 1968		



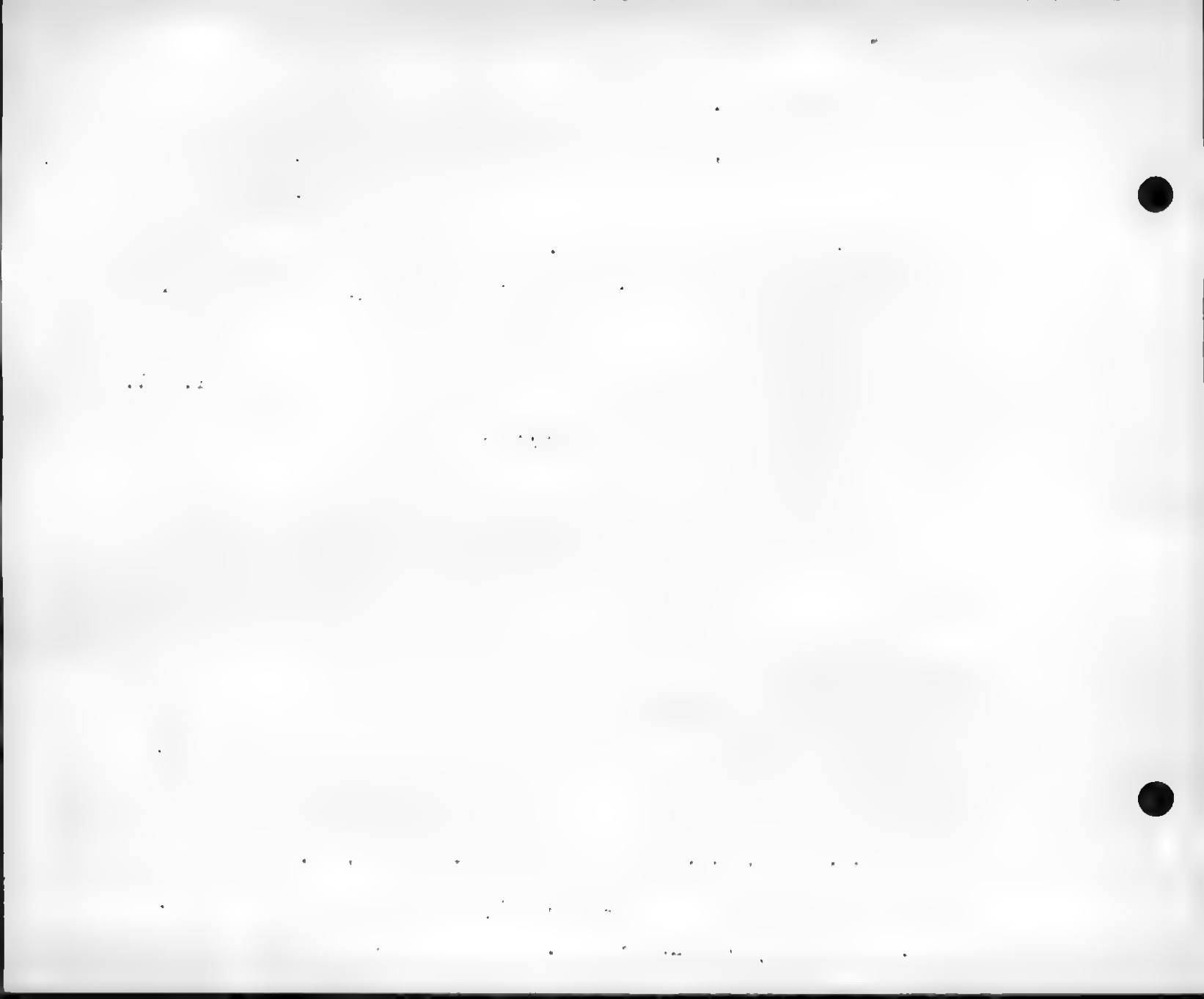
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 4-12 1968		2b. HOJR
HARRY W. PETERSON							VIA. M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	white	Nov 8, 1919	48 YRS			4-12 1968	3 PM
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Ohio	USA			Baltimore		Middle River	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
2207 Baker Ave.		Millwright		Aircraft			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER			
Maryland	Baltimore	Middle River		2207 Baker Ave.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
Unknown					Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		201 01 3894		Margaret Thorpe		Greenville, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4129 A-S-C-V-Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED			
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER			
M.B. Davis, M.D. 6800 Mornington Rd.		Bundall, M.D. 21222					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial	4/19/68	Baltimore, National Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James L. Bruzdziński		1407 Eastern Ave.		APR 18 1968		Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

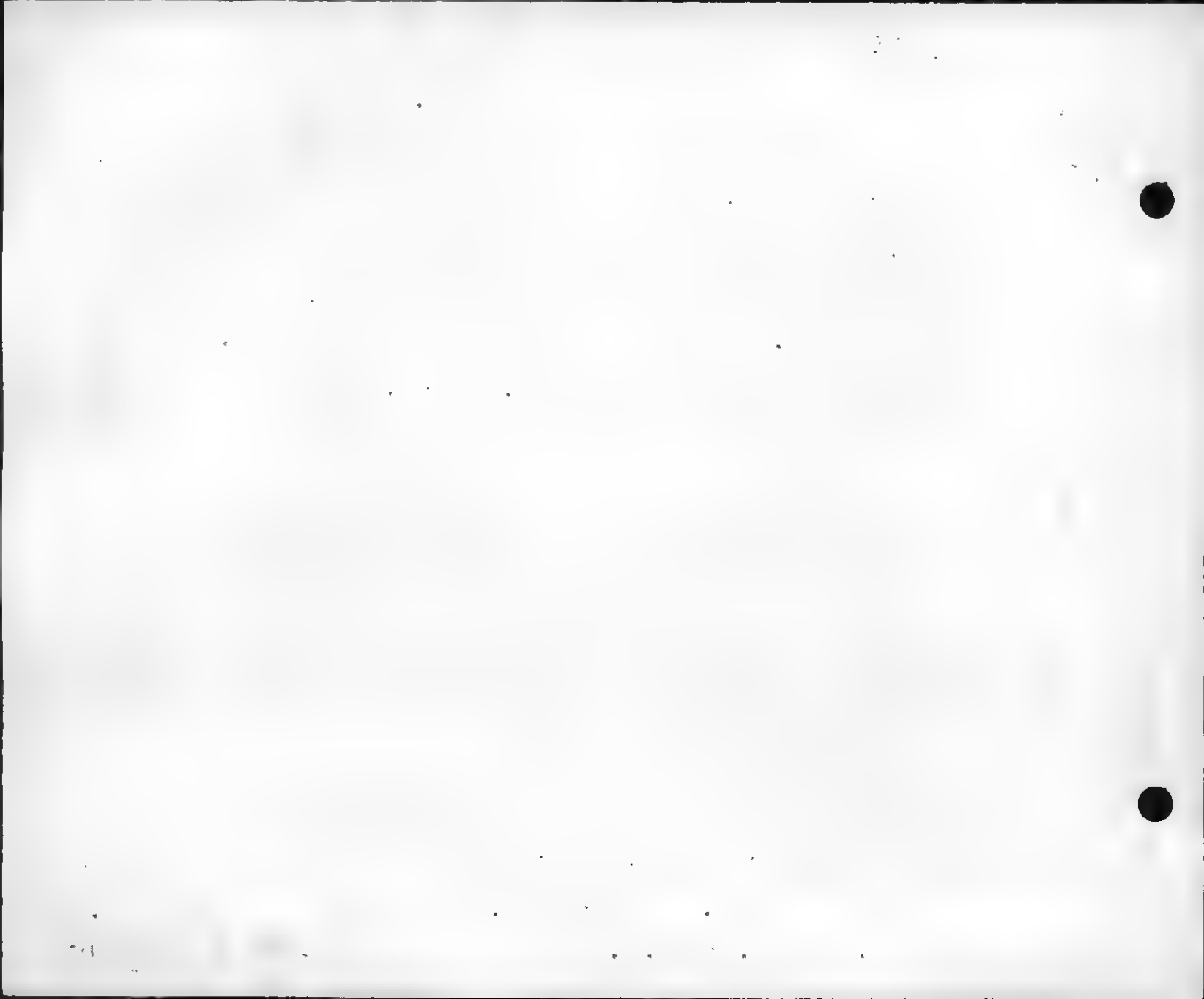


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) Robert Norman Peterson						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 4/20 1968		2b HOUR 3:40 P.M.			
3 SEX M	4 RACE W	5 DATE OF BIRTH 6/21/50	6 AGE (In years last birthday) 17 YRS.	7 UNDER 1 YEAR MONTHS DAYS 	8 UNDER 24 HRS. HOURS MIN 	2c DATE PRONOUNCED DEAD Month 4/20 Day Year 1968		2d HOUR 6:30 P.M.			
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10 CITY OR TOWN OF DEATH Arbutus			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) -			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Student			12b KIND OF BUSINESS OR INDUSTRY School		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.			13b COUNTY -		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2211 Pelham Ave. 21213		
14 FATHER'S NAME First Robert G. Middle Peterson Last 				15 MOTHER'S MAIDEN NAME First Dolores Middle V. Last Tanski							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO 		17 INFORMANT Mr. Robert G. Peterson				ADDRESS (Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation By Drowning 910.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4292											
19a DATE OF OPERATION 				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year 3:40 P.M. 4-20 19 68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Driveway			21f LOCATION Street or R.F.D. No City or Town Halethorpe County Baltimore State Id.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James N. Frederick M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/20/68			
EXAMINER'S NAME (Type) James N. Frederick Md						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) 1311 Landon Ave Balto. Md. 21229	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 4/24/68.		23c NAME OF CEMETERY OR CREMATORY Crestlawn Gdns. of Memories			23d LOCATION (City or Town) (County) (State) West Friendship, Md.			
24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltimore, Md. 21214						25a REC'D BY REGISTRAR APR 22 1968		25b REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) KARL Joseph PFAU			2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 4 17 1968			2b. HOUR ? M			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 9-1-08	6 AGE (In years last birthday) 59 YRS	7 UNDER 1 YEAR MONTHS DAYS 	7 UNDER 24 HRS HOURS MIN 	2c. DATE PRONOUNCED DEAD Month 4 Day 20 Year 1968		2d. HOUR 2pm	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 615 Meadow Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution) STATE md.			13b. COUNTY Balto		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 615 Meadow Rd.		
14. FATHER'S NAME First Joseph Middle PFAU Last Christina			15 MOTHER'S MAIDEN NAME First Christina Middle Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO 		17. INFORMANT ADDRESS Eric M PFAU 1532 Latrobe Blk Terrace				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage - ruptured aorta 952x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH und
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1117									
19a. DATE OF OPERATION 4/22/68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 			21b. TIME OF INJURY Month, Day, Year 4/22/68 HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No City or Town County State 				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John E. Hyle			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4-20-68			
EXAMINER'S NAME (Type) JOHN E. Hyle			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) 7527 Broom Rd						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/22/68		23c. NAME OF CEMETERY OR CREMATORY Garden of Faith		23d. LOCATION (City or Town) (County) (State) Balto Co. Md.		
24. FUNERAL DIRECTOR Kassabn Funeral Home					ADDRESS 7401 Belair Rd.		25a. REC'D BY REGISTRAR APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

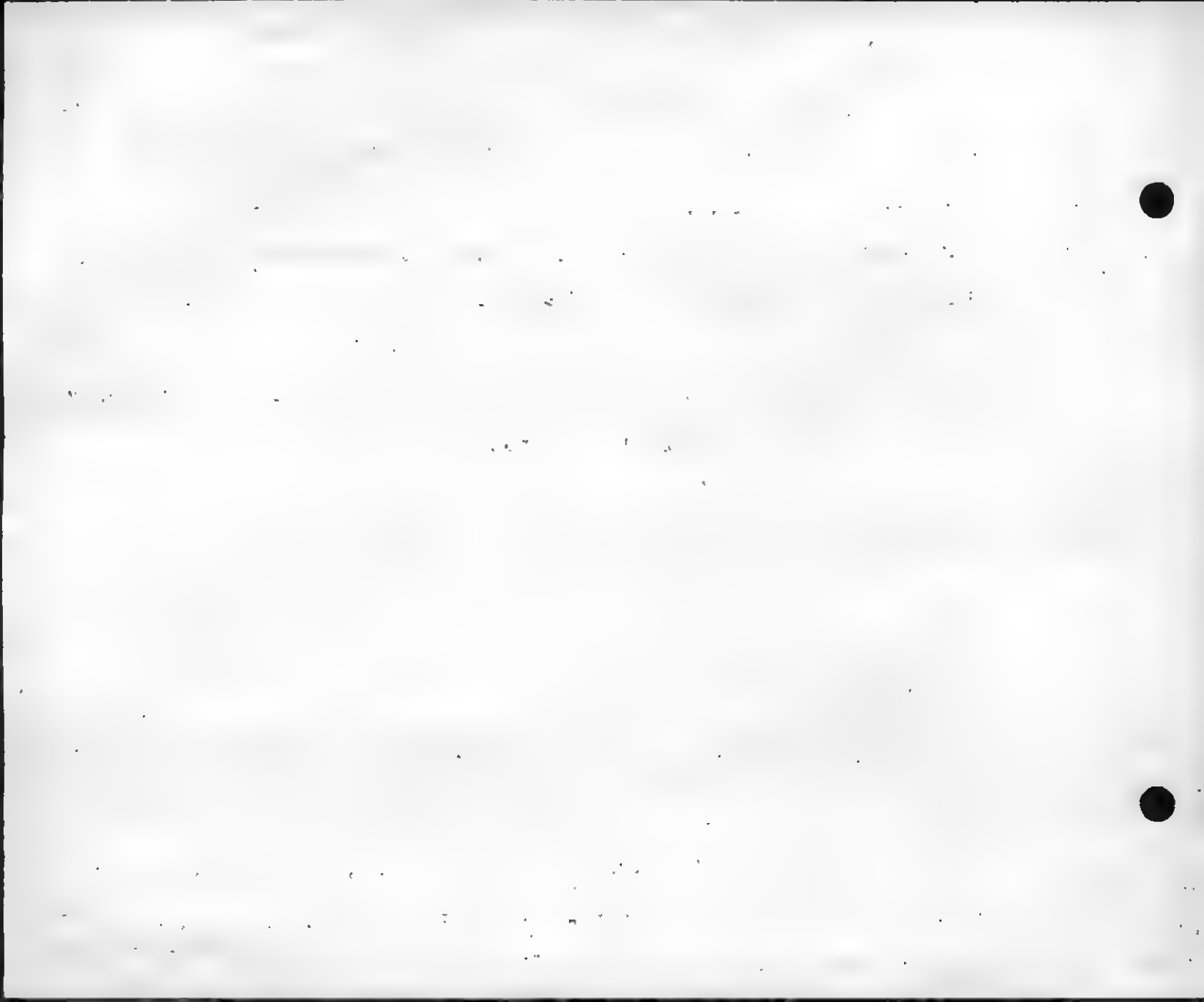
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health.

VR 15 (1)
30M REV 1/68

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05340

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last JOHN HEYWOOD PHILLIPS			2a DATE OF DEATH Month Day Year APRIL 13 1968		2b HOUR 4:10AM
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH APRIL 14, 1906		6 AGE (In years last birthday) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md		
10 CITY OR TOWN OF DEATH FORT HOWARD	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LITHOGRAPHER <i>Crown Cork & Seal</i>	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if not in State address) STATE MARYLAND	13b COUNTY BALTIMORE	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIM 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 617 48TH STREET	
14 FATHER'S NAME First Middle Last CHARLES H PHILLIPS			15 MOTHER'S MAIDEN NAME First Middle Last KATIE COLE		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16b SOCIAL SECURITY NO 213 01 00 51	17 INFORMANT Address CLINICAL RECORDS, VA HOSP, FT HOWARD, MD		
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS 571.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that XX (this hospital) attended the deceased from 11/27/67 , 19____, to 4/13/68 , 19____, that XX (we) last saw the deceased alive on 4/13/68 , 19____, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) XXXXXX view the body after death.					
22b SIGNATURE <i>Chong Choon Han</i> DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 4 13 68	
22d. PHYSICIAN'S NAME (Type) CHONG CHOON HAN, M.D.				22e ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE 4/16/68	23c NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY	23d LOCATION (City or Town) (County) (State) GERMAN HILL RD, BALTIMORE, MD		
24 FUNERAL DIRECTOR ADDRESS MORAN FUNERAL HOME, 3000 E BALTO ST, BALTO MD			25a REC'D BY REGISTRAR DATE APR 16 1968	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-1. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

30342 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) MICHAEL JOSEPH PHILLIPS			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year APRIL 12, 1968			2b HOUR 11 P.M.		
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH SEPT. 29 1921	6 AGE (In years last birthday) 46 YRS	7 UNDER YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD APRIL 12		2d HOUR 11 P.M.
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U. S. A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7204 CONLEY ST.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) MACHINIST		12b KIND OF BUSINESS OR INDUSTRY AM. CAN Co		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD		13b COUNTY BALTO		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7204 CONLEY ST.
14 FATHER'S NAME First Middle Last FRANK PHILLIPS			15 MOTHER'S MAIDEN NAME First Middle Last ANTOINETTE PAWLEK					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b SOCIAL SECURITY NO 215-14-4034			17 INFORMANT ADDRESS MRS. VERA PHILLIPS 7204 CONLEY ST.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Cardi-Vascular Disease 120 DUE TO, OR AS A CONSEQUENCE OF Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE M.B. Davis			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4/13/68		
EXAMINER'S NAME (Type) M.B. Davis M.D. - 6800 Mount Vernon Ave			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b DATE APRIL 16, 1968		23c NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY		23d LOCATION (City or Town) (County) (State) BALTIMORE MD.	
24 FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI			ADDRESS 2525 FLEET ST.		25a REC'D BY REGISTRAR APR 17 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

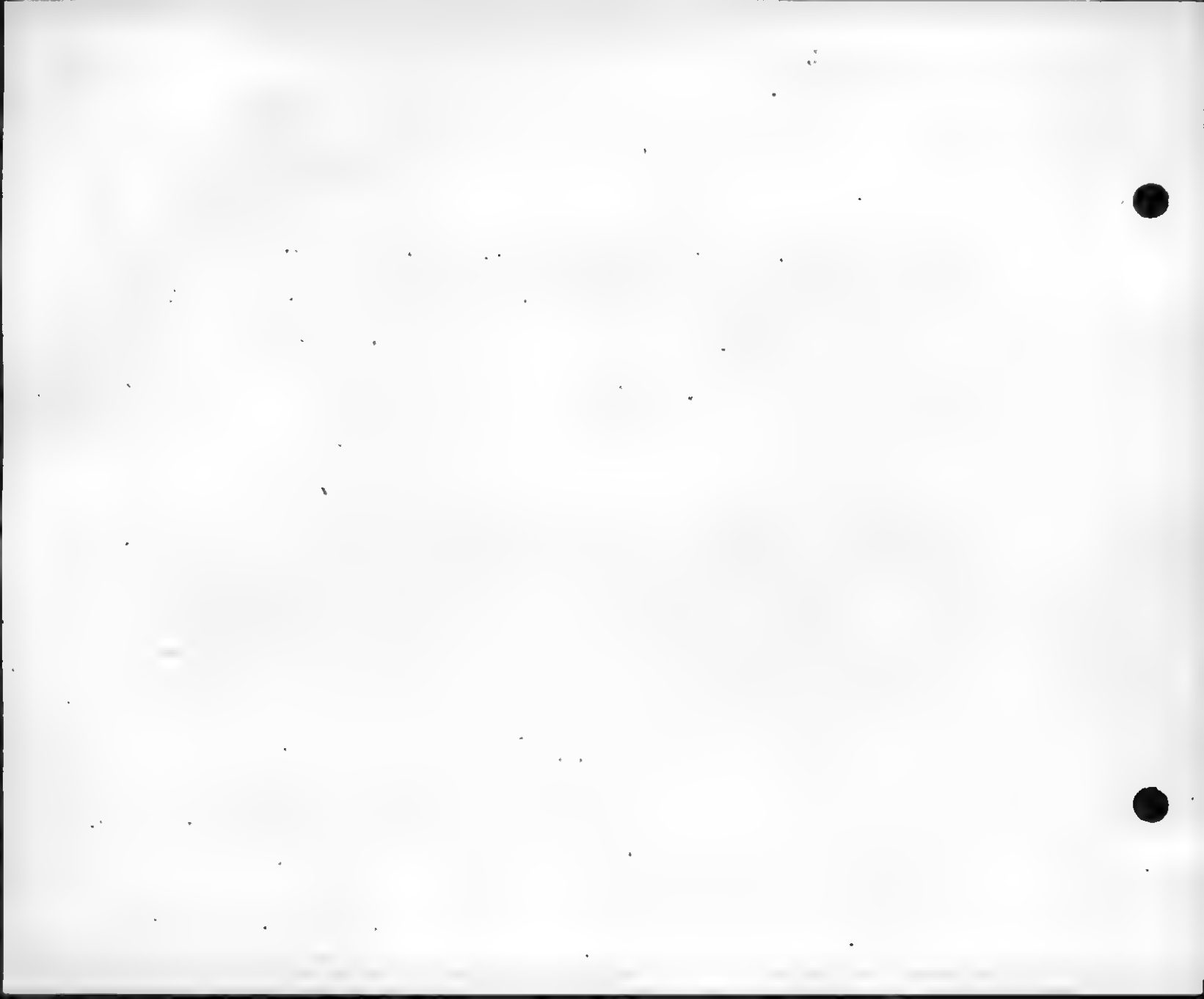


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Bertha Winter Pile			2a. DATE OF DEATH Month 4 Day 17 Year 68		2b. HOUR 12:15 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-28-28		6. AGE (In years lost birthday) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) BALTO. Md.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTO.		Md			
10. CITY OR TOWN OF DEATH Catonsville Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shangri La Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 6100 Woodington Rd					
14. FATHER'S NAME First Louis Middle Winter Last 			15. MOTHER'S MAIDEN NAME First Bertha Middle Roeder Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 212-01-16231		17. INFORMANT Rose Loefler Address 4401 Roland Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left Lower Lobe pneumonia					1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-vascular Accident					1 month
(c) A.S.C.V.D.					years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 4 Day 17 Year 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No. City or Town County State 	
22a. I certify that (I) (this hospital) attended the deceased from 2 April 68 , 19 68 , to 17 Apr , 19 68 , that (I) (was) last saw the deceased alive on 12 Am , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death.					
22b. SIGNATURE Ralph E. Updike MD				22c. DATE SIGNED 17 Apr 68	
22d. PHYSICIAN'S NAME (Type) Ralph E. Updike MD				22e. ADDRESS 31 Dogwood Drive	
23a. BURIAL, CREMATION, CREMATION		23b. DATE 4/20/68		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
23d. LOCATION (City or Town) Baltimore		(County) Maryland		(State) 	
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC, BALTO. MD.				25a. REC'D BY REGISTRAR APR 22 1968	
ADDRESS 				25b. REGISTRAR'S SIGNATURE Charles Judge	



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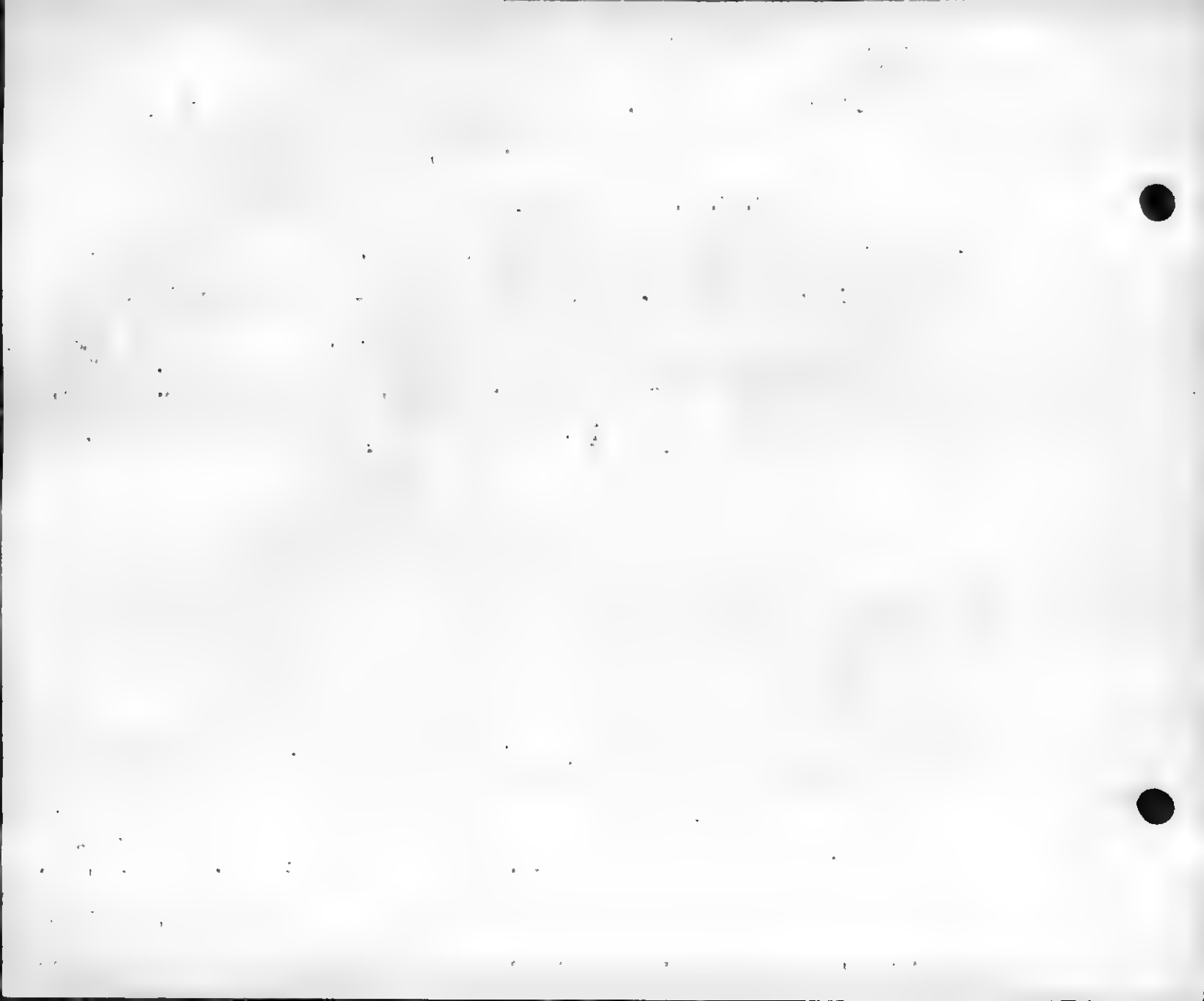
VR A15 (4)
30M REV 1/68

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30345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Arthur C. Pinder			2a. DATE OF DEATH Month Day Year April 23 1968		2b. HOUR 7A. M
SEX Male	4. RACE White	5. DATE OF BIRTH Oct. 8, 1885		6. AGE (In years last birthday) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ridgeway Manor Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Guard	12b. KIND OF BUSINESS OR INDUSTRY Arcrods	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8221 Longpoint Road	
14. FATHER'S NAME First Middle Last Solomon Pinder			15. MOTHER'S MAIDEN NAME First Middle Last Fannie Knotts		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 216-03-6600	17. INFORMANT Address Md. 21222 Thomas Pinder, 8221 Longpoint Rd. Dundalk,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sleep apnea</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1967, to 530a, 1968, that (I) (we) last saw the deceased alive on 22 Apr 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William Goodman M.D.				22c. DATE SIGNED 21222	
22d. PHYSICIAN'S NAME (Type) William Goodman		22e. ADDRESS 1334 Sulphur Spring Rd. Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/26/68	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			25a. REC'D BY REGISTRAR DATE APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles J. J. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last MILTON A PLATT			2a. DATE OF DEATH Month Day Year 4/20/68		2b. HOUR 6:45 PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 1/31/89		6. AGE (in years lost birthday) 79 YRS.	7. UNDER 1 YEAR MONTHS DAYS 79
7a. BIRTHPLACE (State or foreign country) BALT.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALT Md		
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SHANGRI LA N.H.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINIST	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b. COUNTY BALTO	13c. CITY OR TOWN MD.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 638 STAMFORD Rd	
14. FATHER'S NAME First Middle Last MATHEW W PLATT		15. MOTHER'S MAIDEN NAME First Middle Last E. Schmidt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 705-03-2512		17. INFORMANT Address LOUIS PLATT 638 STAMFORD Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) TERMINAL Bronchopneumonia 4127 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) GENERALIZED Arteriosclerosis 18 months years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 20 , 1966, to April 20 , 1968, that (I) (we) last saw the deceased alive on April 20 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Melvin N Borden MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/20/68	
22d. PHYSICIAN'S NAME (Type) MELVIN N. BORDEN M.D.				22e. ADDRESS 5000 BALTO NAT'L PIKE, BALTO MD 21224	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-23-68	23c. NAME OF CEMETERY OR CREMATORY LARKIN PARK CEM.		23d. LOCATION (City or Town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR Walter Funeral Home 5711 Edmond Ave		25a. REC'D BY REGISTRAR APR 22 1968		25b. REGISTRAR'S SIGNATURE [Signature]	





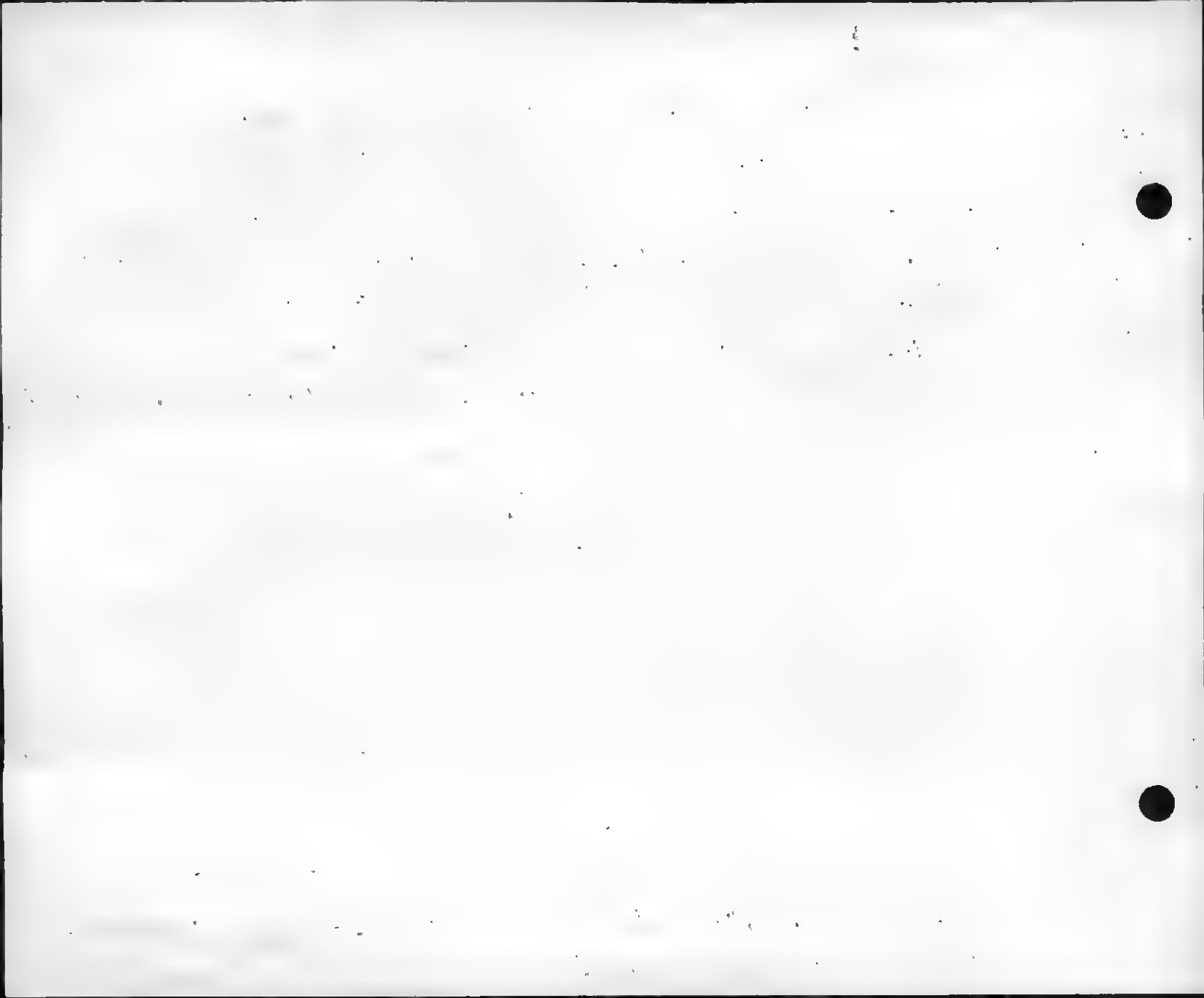
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Catherine Louise PORTER			2a DATE OF DEATH Month Day Year April 11, 1968			2b HOUR 9:30 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH December 23, 1907		6 AGE (In years last birthday) 60 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md			
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home			
13a USUAL RESIDENCE (Where deceased lived, if institution address and) STATE Maryland		13b COUNTY Lutherville		13c INSIDE CITY (LMA 157) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1201 Longford Rd.			
14 FATHER'S NAME First Middle Last Edward J. Naughton				15 MOTHER'S MAIDEN NAME First Middle Last Francis Gravenstein					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give year or dates of service) No None		16b SOCIAL SECURITY NO.		17 INFORMANT Address Fred W. Porter, 1201 Longford Rd., Lutherville					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple pulmonary emboli +30.9 DUE TO, OR AS A CONSEQUENCE OF (b) Intra-cranial hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured congenital saccular aneurysm of the anterior cerebral artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Md.
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from 3/12/1968, to 4/11/1968, that (X) (we) last saw the deceased alive on 4/11/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lawrence F. Misanik, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 11, 1968			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS 7620 York Rd., Towson, Md. 21204							
23a BURIAL, CREMATON, REMOVAL (Specify) Burial		23b DATE Apr. 15, 1968		23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d LOCATION (City or Town) (County) (State) Cockeysville, Maryland			
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REC'D BY REGISTRAR			



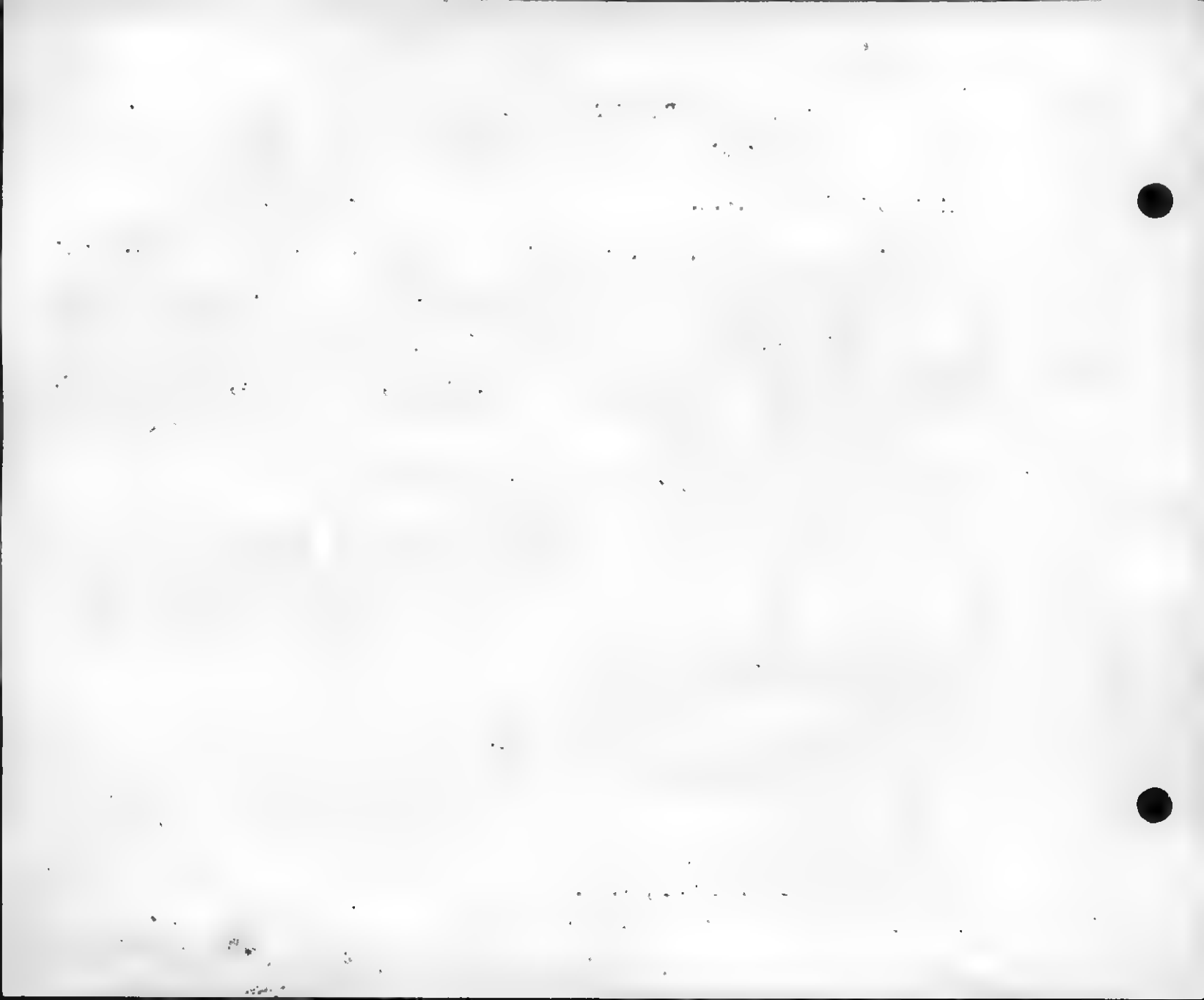
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VR 115 (4)
301A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

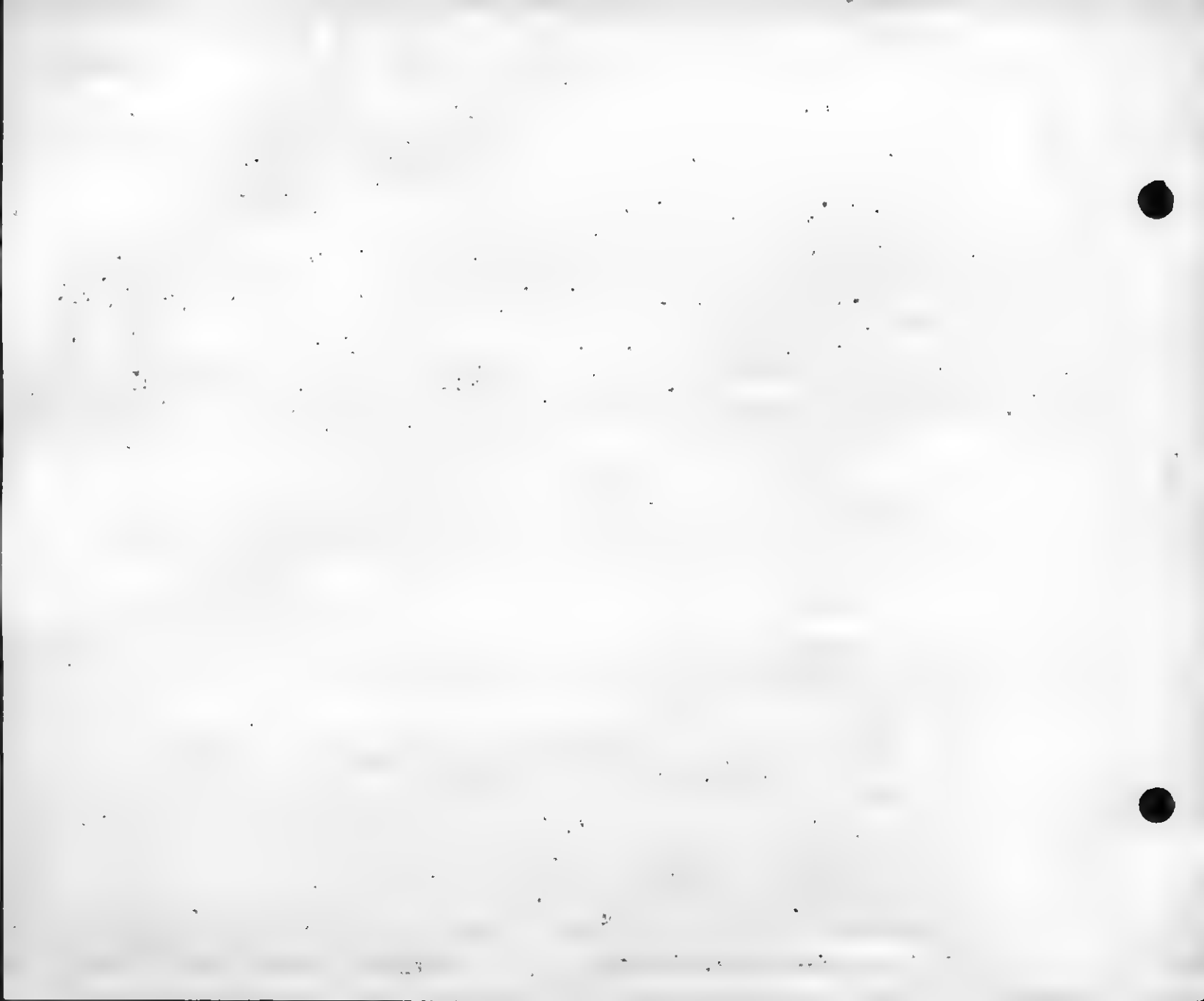
DECEASED-NAME (Type or print) WESTRY			First Middle Last BURNETT POWELL			2a. DATE OF DEATH Month 4 Day 25 Year 68			2b. HOUR 3:25A M						
3 SEX MALE			4 RACE Colored			5 DATE OF BIRTH 6/10/07			6 AGE (In years last birthday) 60 YRS			7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY			12b. KIND OF BUSINESS OR INDUSTRY Ins. Company			
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) INSURANCE AGENT			12b. KIND OF BUSINESS OR INDUSTRY Ins. Company			12c. COMPANY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2330 W. Lexington Street			
14. FATHER'S NAME First Middle Last MOSES POWELL			15 MOTHER'S MAIDEN NAME First Middle Last Coral WESTRY			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> WW II			16b. SOCIAL SECURITY NO 217 05 77 42			17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from 3/10/68 , 19 68 , to 4/25/68 , 19 68 , that (H) (we) last saw the deceased alive on 4/25/68 , 19 68 , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.															
22b. SIGNATURE <i>Howard C. Krayer</i>												DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/25/68	
22d. PHYSICIAN'S NAME (Type) HOWARD C. KRAYE												22e. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 4-30-68				23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				ADDRESS ELROY O. WILSON FUNERAL HOME				25a. REC'D BY REGISTRAR APR 26 1968				25b. REGISTRAR SIGNATURE <i>Charles Judge</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05352									
1. DECEASED-NAME (Type or print) First Middle Last LAWRENCE STEWART PRICE			2a. DATE OF DEATH Month Day Year April 28 1968			2b. HOUR 1:30 A.M.			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 11-3-19		6 AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Harris, Somerset, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) C.P.A.		12b. KIND OF BUSINESS OR INDUSTRY Accounting			
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 10005 Oakfern Road	
14. FATHER'S NAME First Middle Last Thomas L. PRICE			15. MOTHER'S MAIDEN NAME First Middle Last Ethel BERRY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. 215-03-3386		17. INFORMANT Mrs. Rosalie E. Price		Address 10005 Oakfern Road Randallstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>12 hr.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Ex...</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>68</u> , to <u>4-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel Bakal MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-28-68			
22d. PHYSICIAN'S NAME (Type) DANIEL BAKAL, MD		22e. ADDRESS 5600 LOCKHART DR							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-1-68		23c. NAME OF CEMETERY OR CREMATORY Ward's Chapel		23d. LOCATION (City or Town) (County) (State) Balto. Md.			
24. FUNERAL DIRECTOR Harris Byers ROTH 828 Liberty Rd.				25a. REC'D BY REGISTRAR DATE MAY 01 1968		25b. REGISTRAR'S SIGNATURE John H. Judge			



21

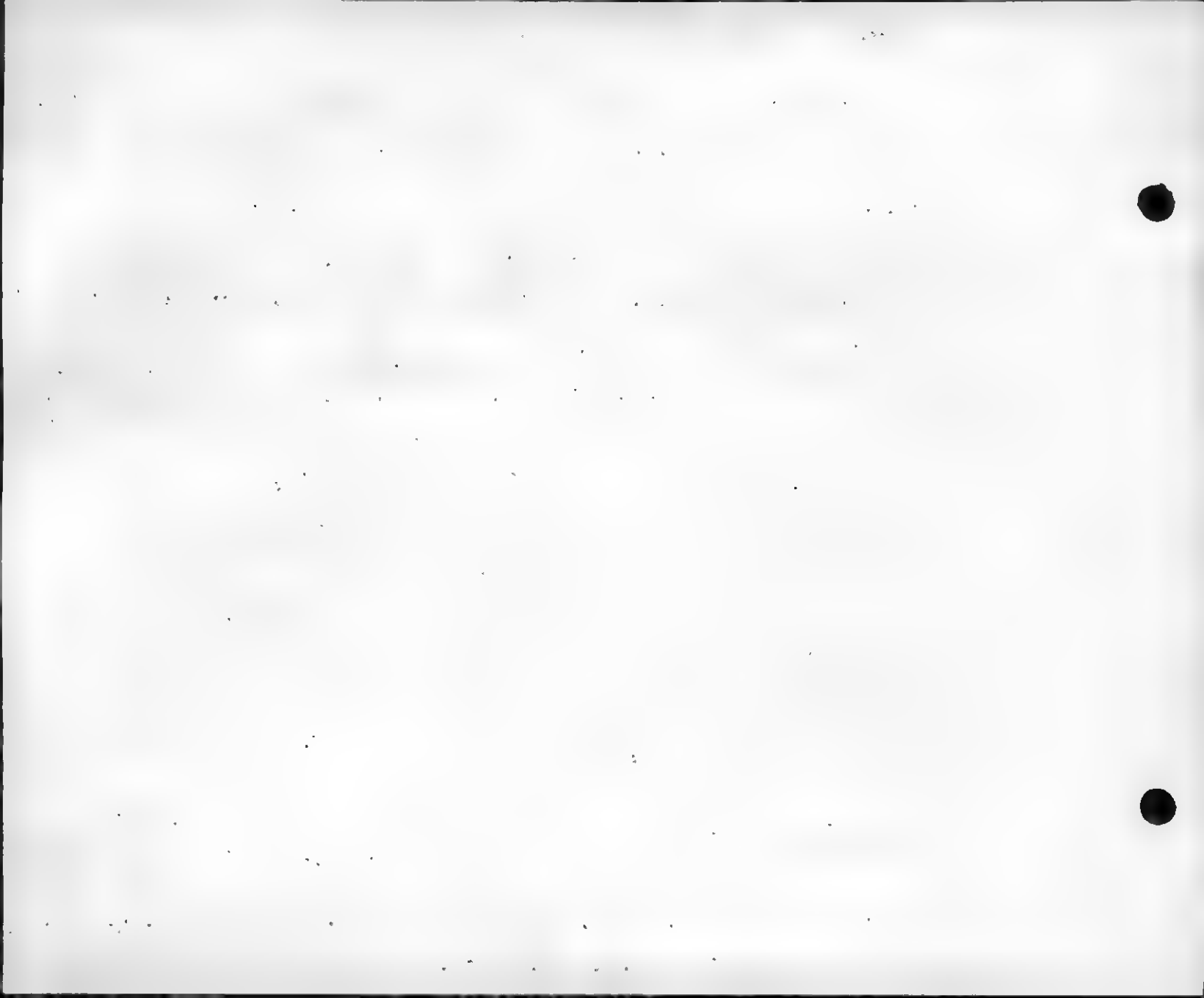
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First MARGARET Middle DALE Last PRICE			2a. DATE OF DEATH 4/2/68 Month Day Year			2b. HOUR 5:15 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 2, 1874			6. AGE (In years last birthday) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md	
10. CITY OR TOWN OF DEATH Lutherville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) College Manor			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Balto.		13c. CITY OR TOWN Woodbrook		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6425 Murray Hill Rd.	
14. FATHER'S NAME First William Middle Henry Last Harrison			15. MOTHER'S MAIDEN NAME First Anna Middle Dale Last Beaver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 220-44-3876		17. INFORMANT : daughter Address Balto.-21212 Mrs. Emily P. Richardson, 6425 Murray Hill					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>arterio sclerosis</u> (b) <u>arterio sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>arterio sclerosis</u> (c) <u>arterio sclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Smoking</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 195, 19 to Apr 2, 1968, that (I) (we) last saw the deceased alive on Apr 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. Paul Byerly MD					DEGREE MD		22c. DATE SIGNED 4/3/68		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) M Paul Byerly					22e. ADDRESS 5820 York Rd Balto (2nd fl)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co., Md.			
24. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av., Balto.					ADDRESS 21201		25a. REC'D BY REGISTRAR DATE APR 4 - 1968		25b. REGISTRAR'S SIGNATURE J. C. Jones	



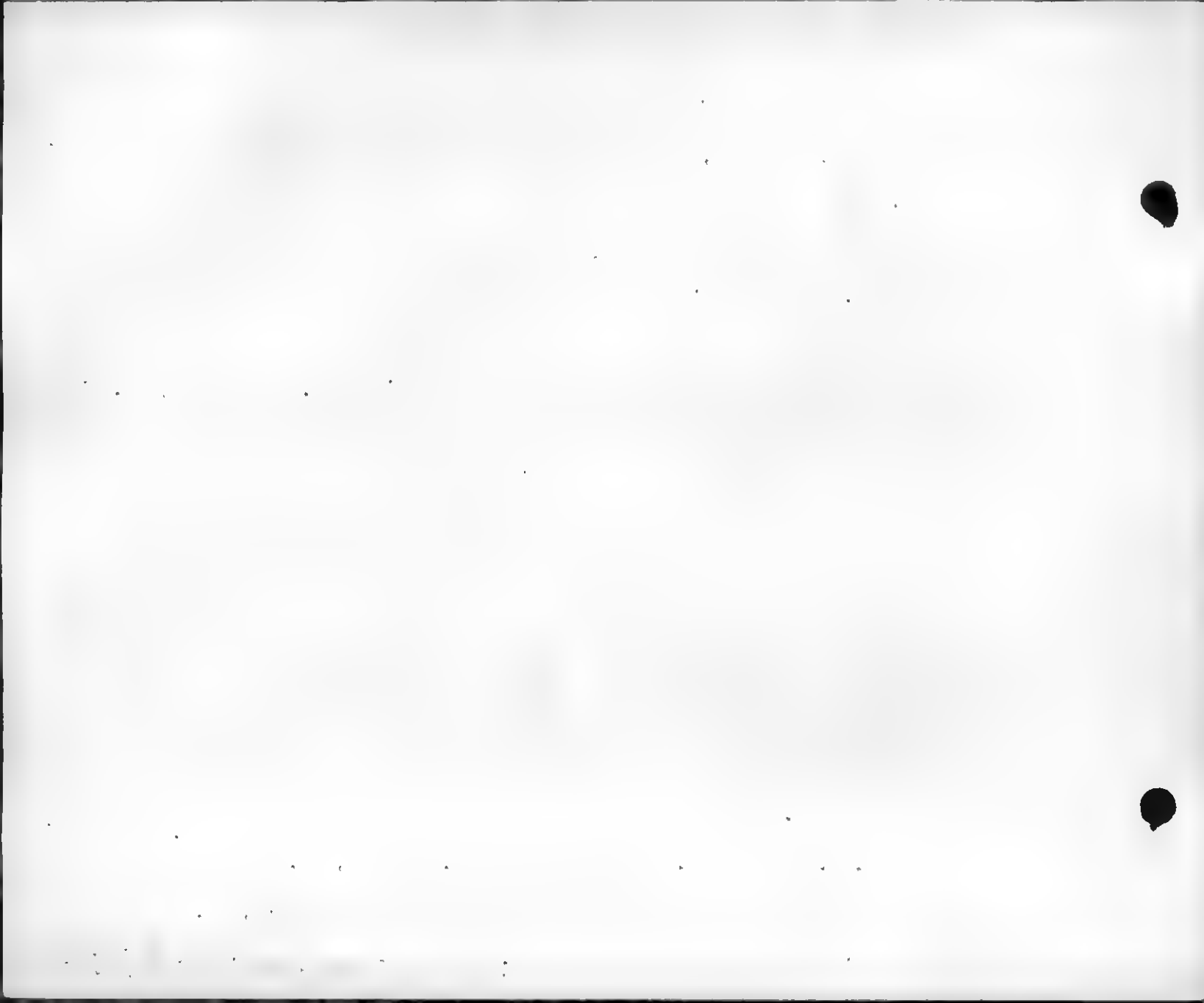
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Item 52 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First NEAL Middle EVANS Last PRYNE			2a. DATE KNOWN OF DEATH Month 4 Day 6 Year 1968			2b. HOUR 11-10 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec 26, 1897	6. AGE (In years last birthday) 70 yrs	7. UNDER 1 YEAR MONTHS DAYS HOURS Min	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 4 Day 9 Year 1968			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		9. COUNTY OF DEATH Baltimore			12b. KIND OF BUSINESS OR INDUSTRY Merchant Marine		
10. CITY OR TOWN OF DEATH Essex (21)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1432 Galena Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Seaman Ship Captain			12b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1432 Galena Road	
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 086 12 8529		17. INFORMANT ADDRESS James Pine 24 Penna. Ave Towson, Md. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CHS + Hypertensive C-V Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>443X Cholesterol</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>M B Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>4-9-68</u>			
EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Mornington Rd. Dundalk, Md. 21222				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION Burial		23b. DATE 4/16/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md. Roanoke, Va.			
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.				25a. REC'D BY REG STRAR DATE APR 16 1968		25b. REG STRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-54
30M REV 7-59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Joseph Woodley</i> <i>QUEEN</i>		2a DATE OF DEATH <i>4</i> Month <i>1</i> Day <i>1968</i>		2b. HOUR <i>7:30 PM</i>
3 SEX <i>M</i>	4 RACE <i>C</i>	5. DATE OF BIRTH <i>4-27-1913</i>	6 AGE (In years lost birthday) <i>54</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore County, Md.</i>	
10 CITY OR TOWN OF DEATH <i>Mt. Wilson</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Mt. Wilson State Hosp.</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farmhand</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>	13b COUNTY <i>St. Mary's</i>	13c CITY OR TOWN <i>Loverville</i>	13d INSIDE CITY Y.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER
14 FATHER'S NAME First <i>John</i> Middle <i>George</i> Last <i>Queen</i>	15. MOTHER'S MAIDEN NAME First <i>Effie</i> Middle <i>Lammert</i> Last <i>Willie</i>	16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		
16b SOCIAL SECURITY NO. <i>220-16-8249</i>		17. INFORMANT Address <i>Records, Mt. Wilson State Hospital</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage of Cerebrum & Upper medulla</i> <i>150 X</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>191 X</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)	21f LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-27-1968</i> , to <i>4-1-1968</i> , that (I) (we) last saw the deceased alive on <i>4-1-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b SIGNATURE <i>W. Newcomer</i>	DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <i>William Newcomer, M.D.</i>	22e. ADDRESS <i>Mount Wilson, Maryland</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b DATE <i>APRIL 6, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ST. JOSEPH'S CEMETERY</i>	23d LOCATION (City or Town) (County) (State) <i>MORGANZA, ST. MARY'S, MARYLAND</i>	
24 FUNERAL DIRECTOR <i>McLark Mattingly Leonard</i>	ADDRESS <i>1200 N. ...</i>	25a REC'D BY REGISTRAR <i>Charles Judge</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item 5 Film G399 4/17/68												
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR			
First Middle Last Harry James Quick						Month Day Year April 6, 1968			M 11			
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		May 6, 1968 1878			89 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			12b K NO OF BUSINESS OR INDUSTRY			
Md.		U.S.A.				Baltimore			Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b K NO OF BUSINESS OR INDUSTRY			
Woodlawn, Md.			2104 Park Pl.			Florist			Floral			
13a USUAL RES DENCE (Where deceased lived, if nsttut on Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.			Baltimore		Woodlawn				2104 Park Pl.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S M A D E N NAME First Middle Last								
David Taylor				Emma Franklin								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address						
No		218-32-4791		Mrs. Ruth H. Quick-wf.		2104 Park Pl. 21207						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u>										24 hrs		
7124 DUE TO, OR AS A CONSEQUENCE OF <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u>										?		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
<u>PERNICIOUS ANEMIA</u> 2 yrs.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/7</u> , 19 <u>66</u> , to <u>4/6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Joseph S. Blum</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>4/8/68</u>						
22d. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM, MD</u>						22e. ADDRESS <u>1115 N. CALVERT ST.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		4/9/68		Loudon Park Cem.		Baltimore, Md.						
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Wm. Cook-Brooks, West 6212 Balto. Nat'l. pike						APR 11 1968		<u>John A. Judge</u>				

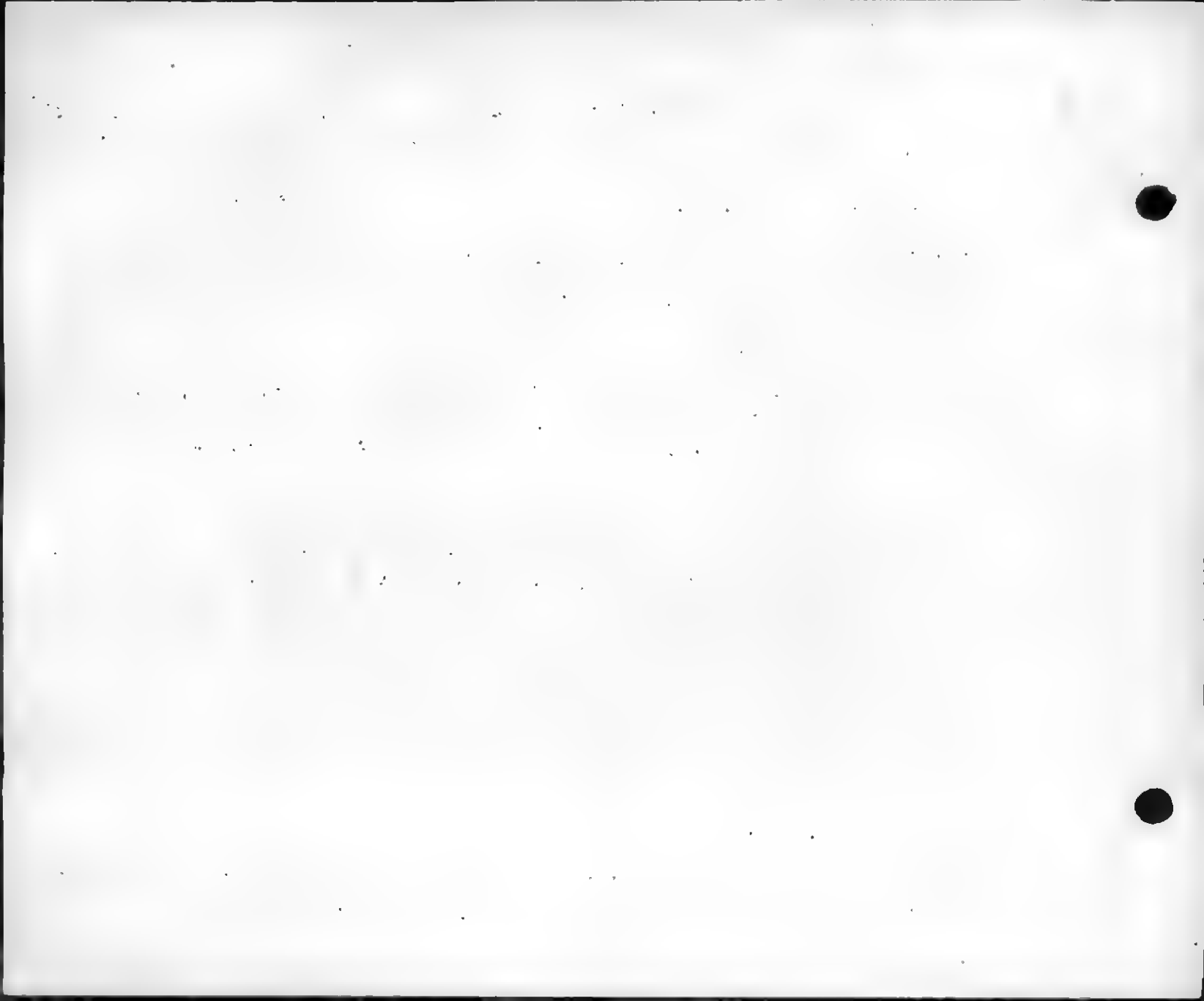


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Robert Frederick RADTKE			2a. DATE OF DEATH Month 4 Day 28 Year 68		2b. HOUR 9:00 ^a _m
3. SEX Male	4. RACE White	5. DATE OF BIRTH 10/16/31		6. AGE (In years lost birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dependent	12b. KIND OF BUSINESS OR INDUSTRY none
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Prince George		13b. CITY OR TOWN Takoma Park	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER -	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service, --)		16b. SOCIAL SECURITY NO. none	17. INFORMANT Address Rosewood Records, Owings Mills, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Orthostatic Necrotizing Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) 36 yrs DUE TO, OR AS A CONSEQUENCE OF (c) 2 wks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 36 yrs					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Mongoloid status with severe mental retardation 36 yrs					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21e. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from 12/9 , 19 56 , to 4/28 , 19 68 , that (1) (we) lost saw the deceased alive on 4/28 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did (did not) view the body after death.					
22b. SIGNATURE Richard A. Jones				22c. DATE SIGNED 4/30/68	
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.				22e. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE May 2, 68	23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery	23d. LOCATION (City or Town) (County) (State) Owings Mills		
24. FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.			25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

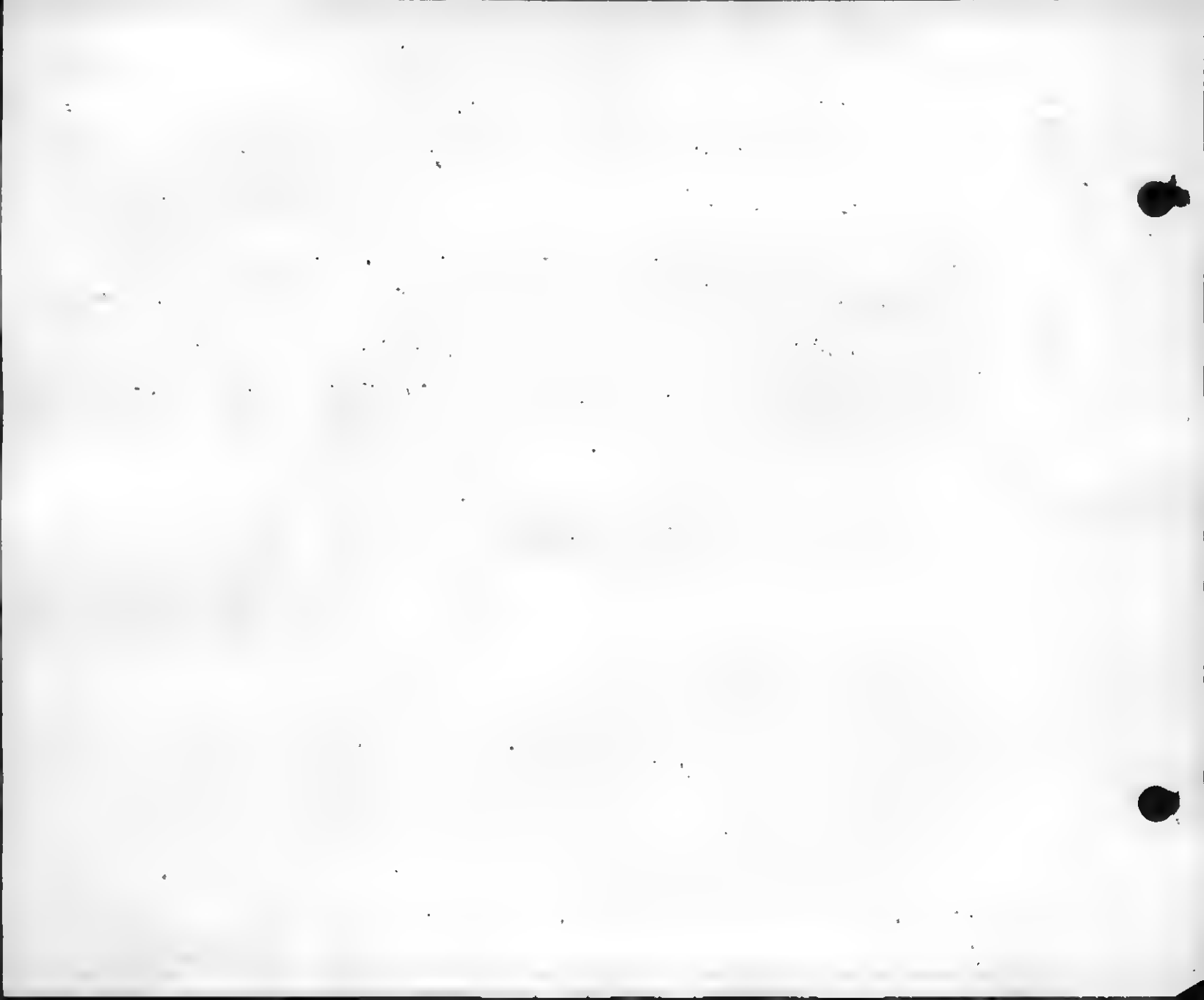


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18c Film 406 10-30-68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
3550
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) PHYLLIS LUCINDA RANDOLPH			2a. DATE OF DEATH Month April Day 27 Year 1968			2b. HOUR 9:15 P M	
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH 3/3/30		6. AGE (In years last birthday) 38 YRS	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Mt. Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTI.		13c. CITY OR TOWN BALTI.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12 N. McKelvey St.		14. FATHER'S NAME First JOSEPH Middle ALLEN Last WILKENS		15. MOTHER'S MAIDEN NAME First ESTELLA Middle WILKENS Last WILKENS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 214-26-0428		17. INFORMANT Address Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ASPHYXIA DUE TO AIRWAY OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF Multiple abscesses and fungus Ball (c) SARCOIDOSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 22.							
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/28 , 19 68 , to 4/29 , 19 68 , that (I) (we) lost saw the deceased alive on 4/29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Newcomer						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.						22e. ADDRESS Mount Wilson, Maryland 21112	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-4-68		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Arbutus Md.	
24. FUNERAL DIRECTOR Chas. F. Kelton 1348 N. Calhoun St				25a. REC'D BY REGISTRAR DATE 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



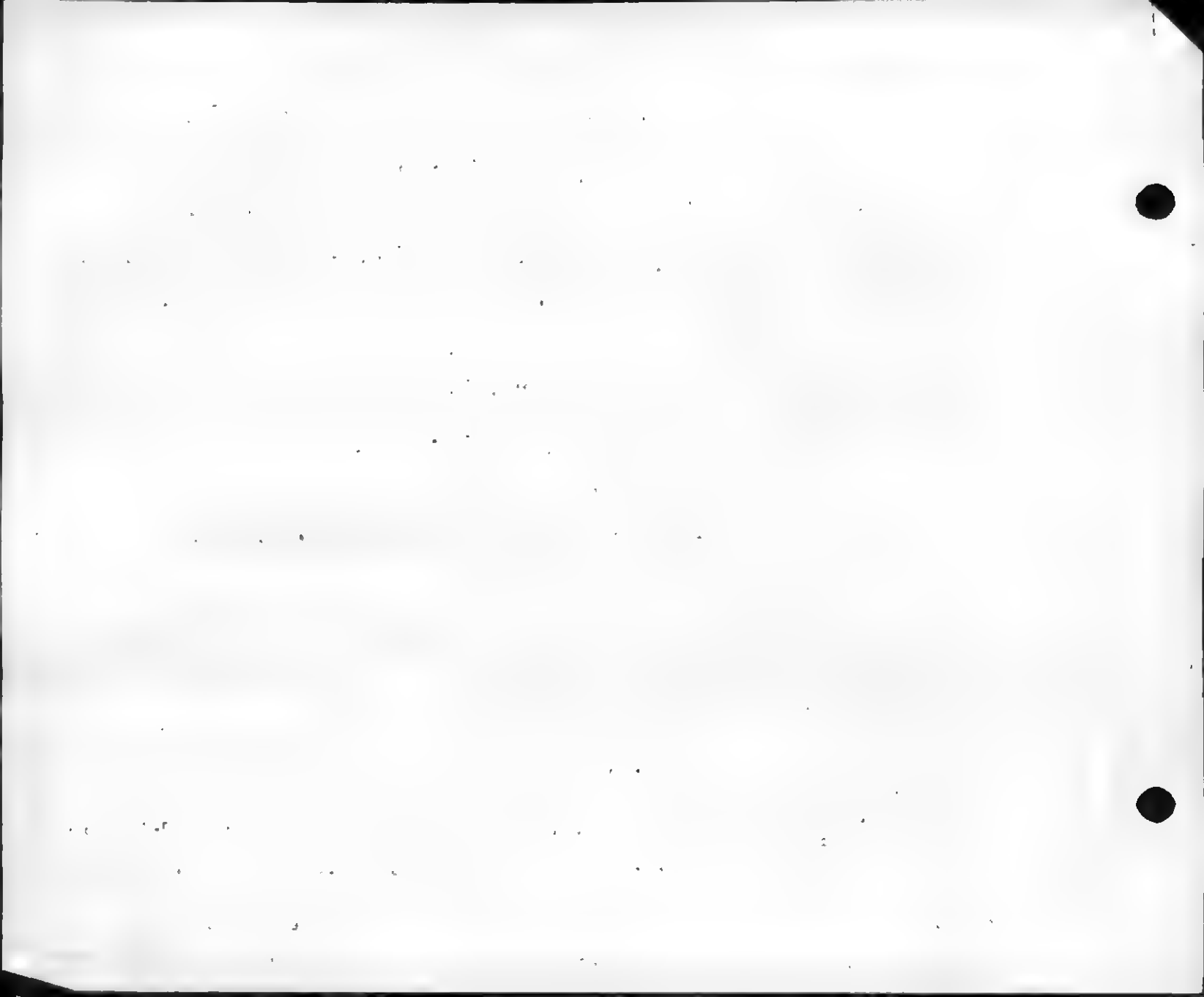
Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
OM REV 3/86



159

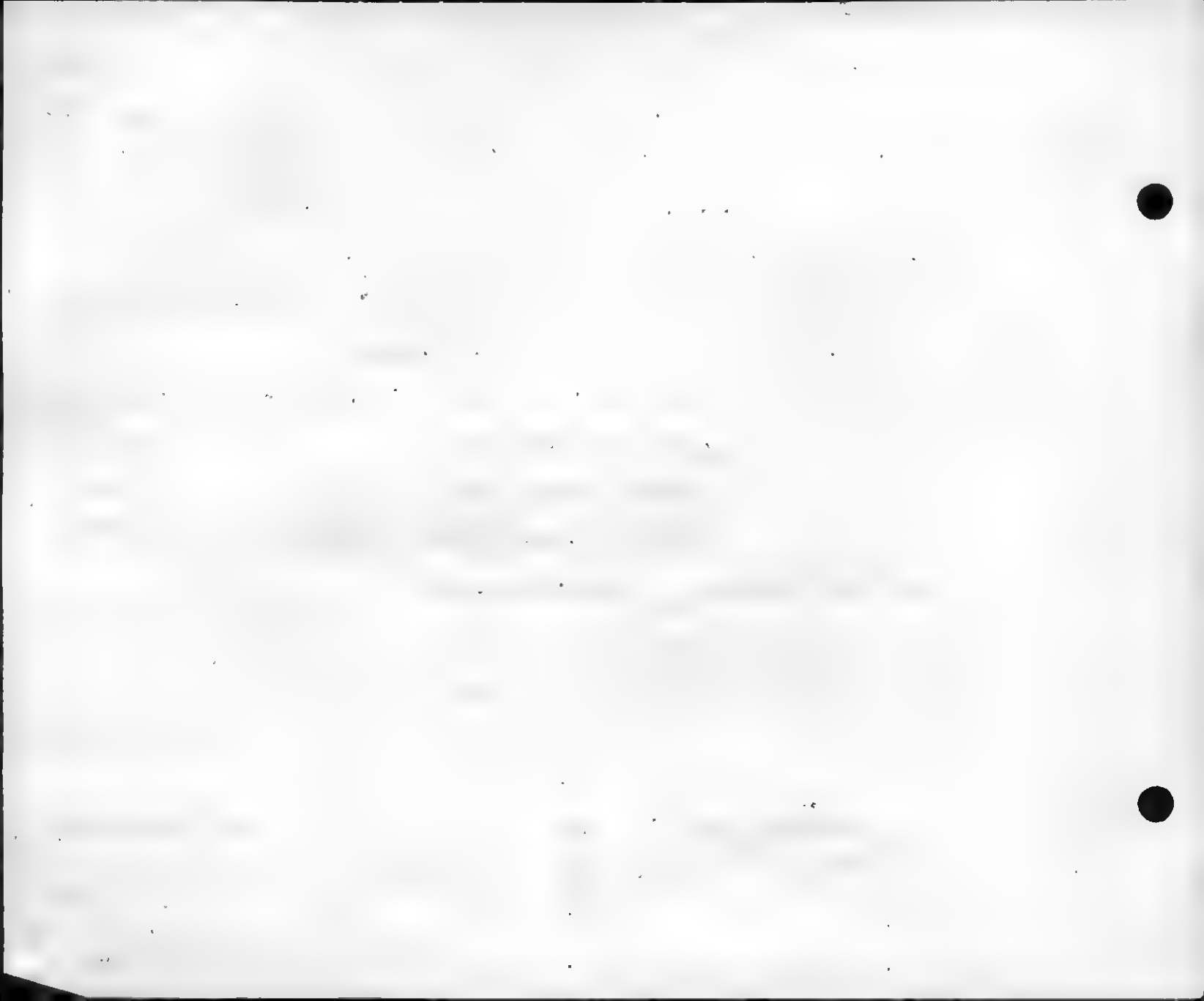
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR			
WILLIAM		STANLEY		RAU				April 12, 1968											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. COUNTY OF DEATH		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			
Male		White		May 3, 1905		62 YRS		Baltimore						West Virginia		St. Joseph Hospital			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. CITY OR TOWN		13c. STREET AND NUMBER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
West Virginia		USA		St. Joseph Hospital		Plater - Self Emp		Plating		Maryland		Baltimore		1011 Upnor Rd. 21212					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
?		?		No		212093677		Mrs. M. Loretta Rau- Same											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
?		?		No		212093677		Mrs. M. Loretta Rau- Same											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
?		?		No		212093677		Mrs. M. Loretta Rau- Same											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
?		?		No		212093677		Mrs. M. Loretta Rau- Same											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
?		?		No		212093677		Mrs. M. Loretta Rau- Same											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
?		?		No		212093677		Mrs. M. Loretta Rau- Same											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Embolism</u> <u>4214</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemophlegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atrial Fibrillation W/ Congestive Heart Failure</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 13 Film G400 5/2/68 kk CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last Flora R. Reed						2a. DATE OF DEATH Month Day Year 4 25 68			2b. HOUR MIN 4:20 PM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH 2/7/92			6 AGE (In years last birthday) YRS. 76		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 327 Haarlem Lane Shangri-La Nursing Home		
14. FATHER'S NAME First Middle Last Louis C. Vogt						15. MOTHER'S MAIDEN NAME First Middle Last Anna Naegel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 219-42-2009			17. INFORMANT Records: Spring Grove State Hospital			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN DAYS YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>HIATAL HERNIA - UNDER NOURISH'</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/25/1967</u> to <u>April 25 1968</u> , that (I) (we) last saw the deceased alive on <u>April 25 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Narciso Aristigueta</u> MD DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 4-25-68		
22d. PHYSICIAN'S NAME (Type) <u>NARCISO ARISTIGUETA.</u>						22e. ADDRESS Spring Grove State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-29-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR APR 26 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

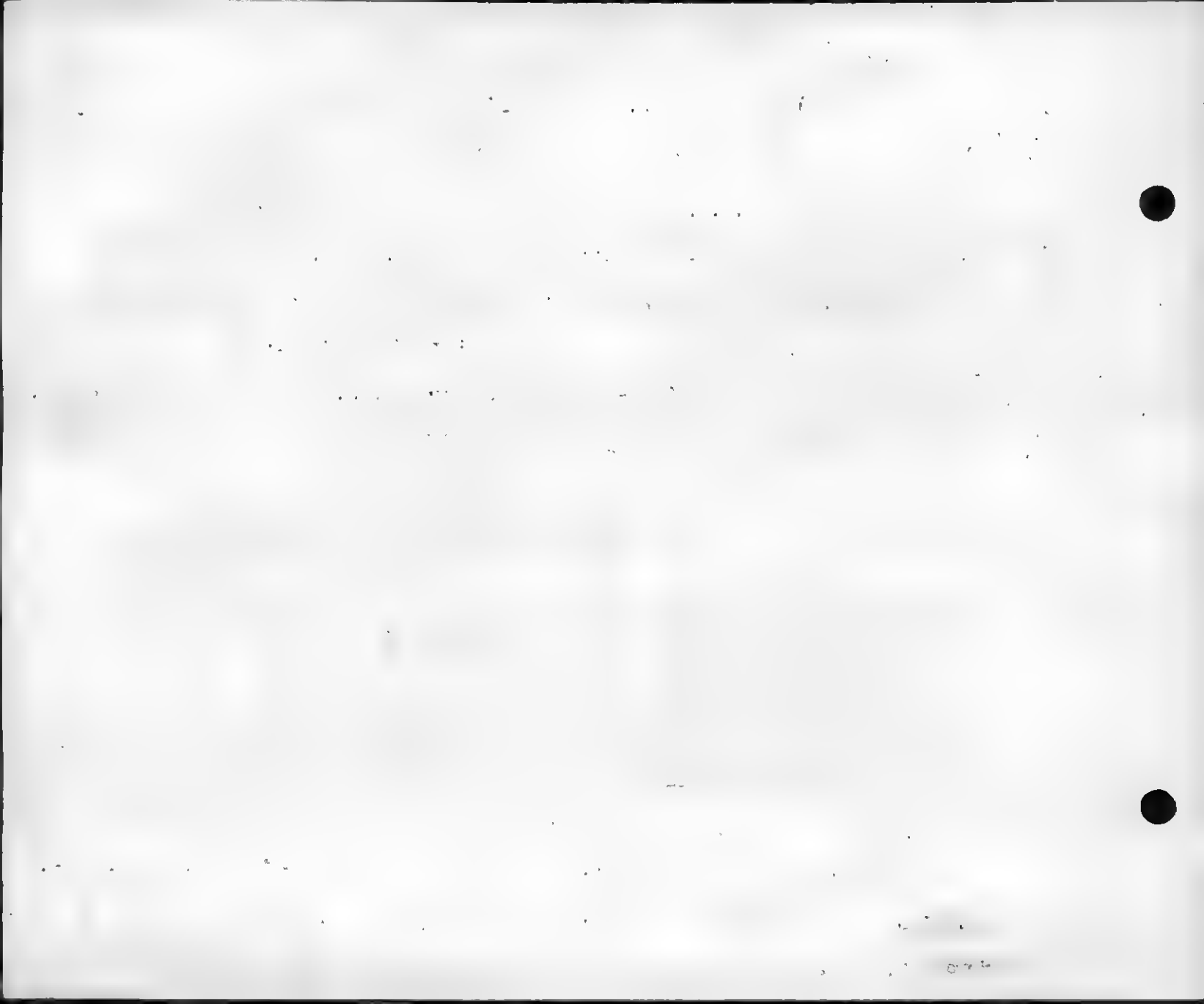


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First GILBERT		Middle W.		Last REED		2a. DATE OF DEATH April Month 16 Day 1968 Year			2b. HOUR 2:05 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-23-1894			6. AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md						
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4306 Barrington Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4306 Barrington Road				
14. FATHER'S NAME First Middle Last James B. Reed				15. MOTHER'S MAIDEN NAME First Middle Last Catherine Russell								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 212-01-5418A		17. INFORMANT Address Mrs. Genevieve M. Reed, 4306 Barrington Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>January 9, 1968</u> , to <u>April 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>John A. Nesbitt, Jr.</u>						22c. DATE SIGNED <u>4-17-68</u>						
22d. PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt, Jr.						22e. ADDRESS 1009 Frederick Road, Catonsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-20-1968		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland						
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229						25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

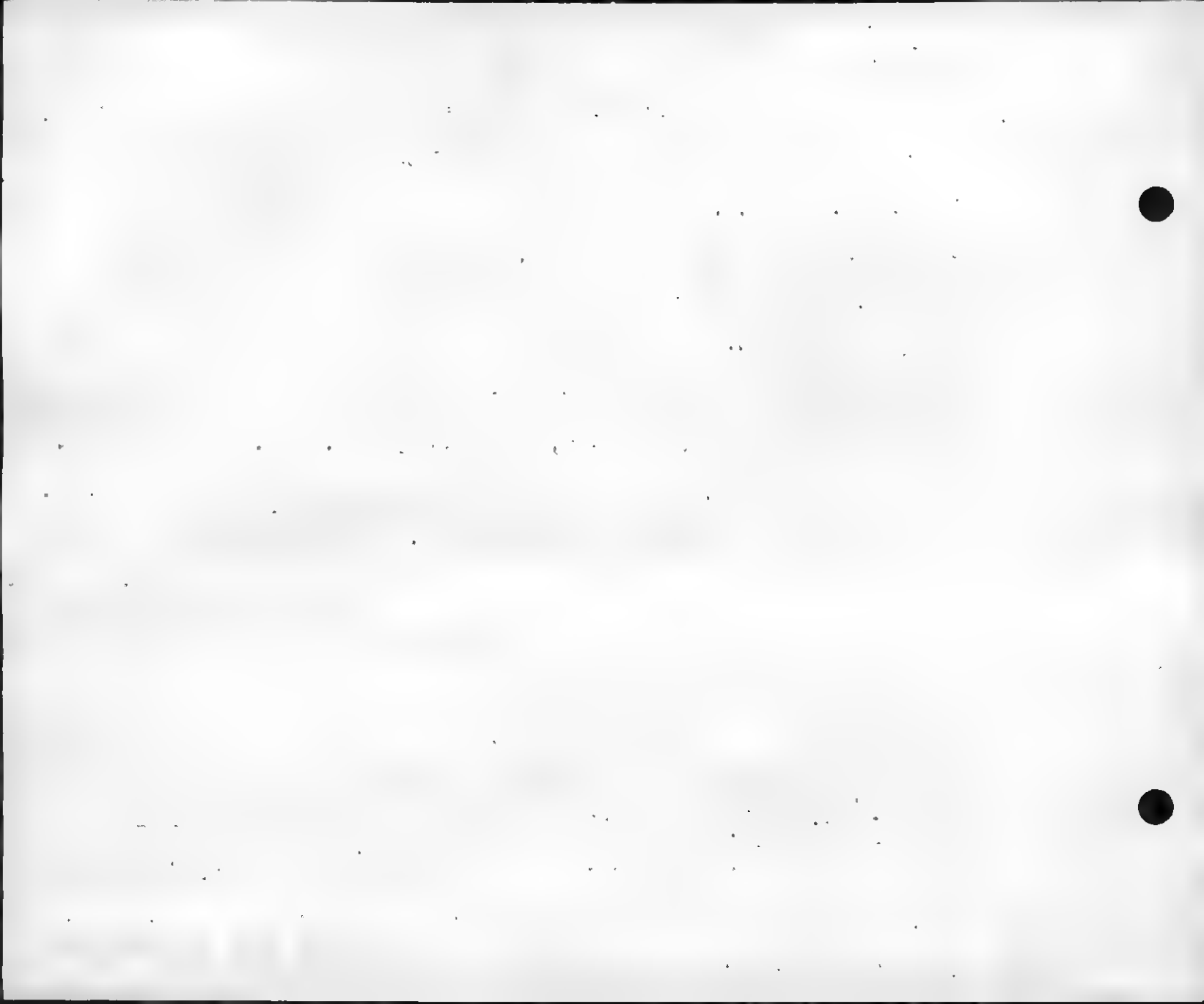
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05360

05362

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Annie		Elizabeth	Reeves	Month April Day 19, Year 1968		1:15 p.		
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
female	White		12/1/86		81 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Balto., Md.		U.S.				Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			Spring Grove State Hospital			Housewife		
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Baltimore		Timonium				245 Coldbrook Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Robert Middle A. Last Murray			First Elizabeth Middle Washbourne Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No		220-46-0623		Records: Spring Grove State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis, bilateral, org. unk.</u>								1 wk.
3744 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Decubitus ulcers over the sacral region</u>								2 wks.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>mitral stenosis and ASCVD</u>								1 month
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>67</u> , to <u>April 19, 1968</u> , that (X) (we) last saw the deceased alive on <u>April 19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Anthony J. Young, M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>4-19-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u>						22e. ADDRESS <u>Spring Grove State Hospital Baltimore, Maryland 21228</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Entombment		4/23/68		Dulaney Valley Cemetery		Cockeysville, Md. Balto.		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D APR 23 1968		25b. REGISTRY SIGNATURE <u>Judge</u>		
Wm. Cook-Brooks Towson 1050 York Rd. 21204				DATE				



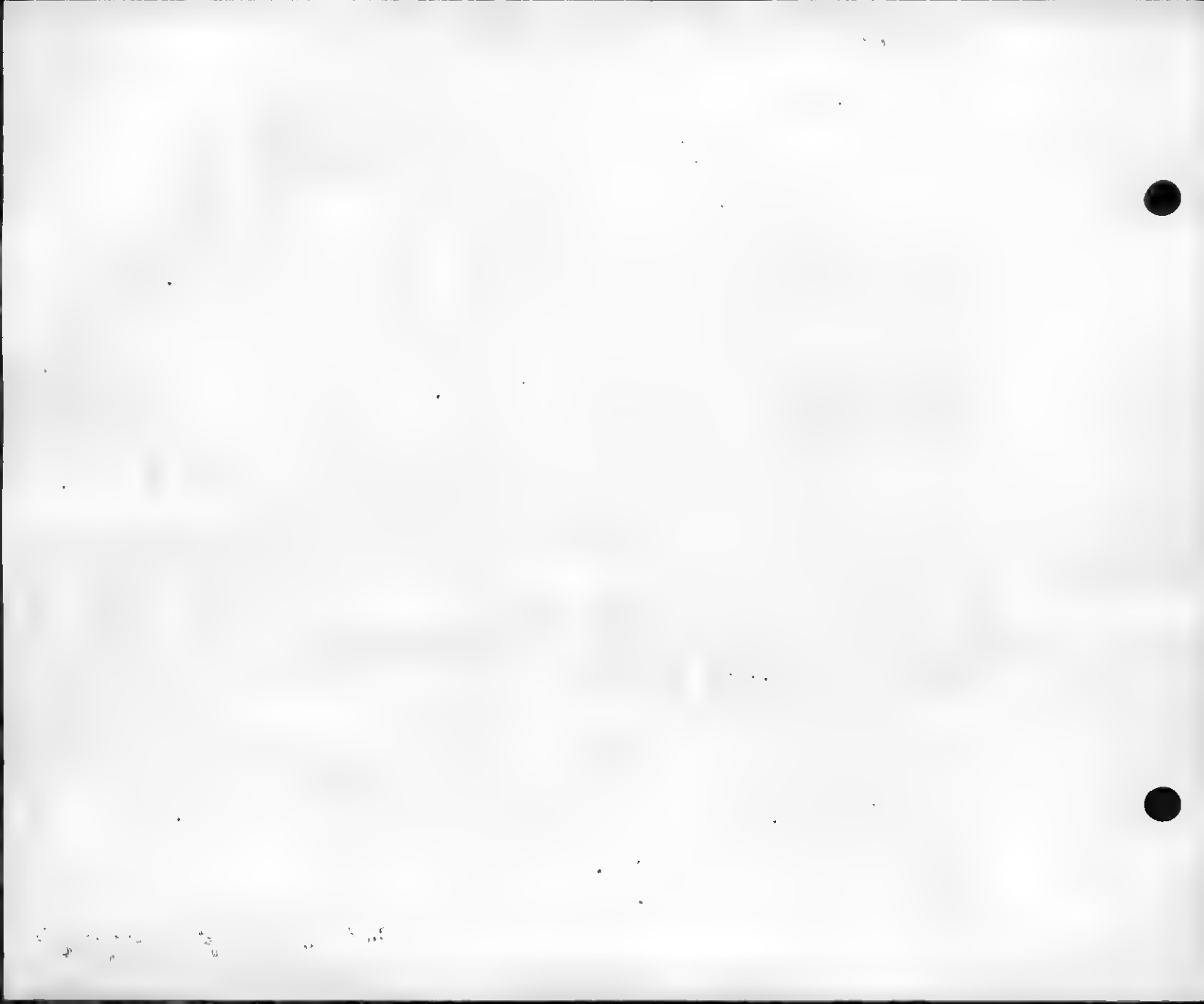
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATSME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) Steven Dennis Reidt						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month April Day 28 Year 1968		2b HOUR 9:45 AM			
3 SEX M	4 RACE W	5. DATE OF BIRTH 6-8-1949	6. AGE (in years last birthday) 18 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD April 28 Month Day Year 1968		2d HOUR 9:45 AM			
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.				MD.	
10. CITY OR TOWN OF DEATH Freeland			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Walker Rd.			12a USAL OCCUPATION (Kind of work done during most of working life, even if retired) Student			12b KIND OF BUSINESS OR INDUSTRY High School		
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Penn.			13b COUNTY York		13c CITY OR TOWN New Freedom		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER Singer Rd.		
14 FATHER'S NAME First Donald L. Middle Reidt Last Reidt				15 MOTHER'S MAIDEN NAME First Dorothy L. Middle Stansbury Last Stansbury							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO 220-5K-5165			17. INFORMANT Donald L. Reidt			ADDRESS New Freedom, Pa. 17349		
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Crushing Injuries of Chest & Head											
DUE TO, OR AS A CONSEQUENCE OF (b) Sudden											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Injuries of Chest & Head											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION 9-1-68				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Probable				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Head on Collision with another Motor Vehicle				21b TIME OF INJURY Month, Day, Year 9-1-68 Hour 9:45 PM				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (at home, farm, street, factory, office building, etc.) Highway		21f LOCATION (Street or R.F.D. No. City or Town County State) Walker Rd - North of Parkton							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from? Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.						ADDRESS (Street, city, town, or county) Freeland, Balto. Md.		22b DATE SIGNED 4/28/68			
23a BURIAL, CREMATION REMAINS (Specify)		23b DATE 5-1-68		23c NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d LOCATION (City or Town) (County) (State) Freeland, Balto. Md.					
24. FUNERAL DIRECTOR Jacob Harrison, New Freedom, Pa.						ADDRESS New Freedom, Pa.		25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE Charles Judge	
						DATE MAY 2 1968					



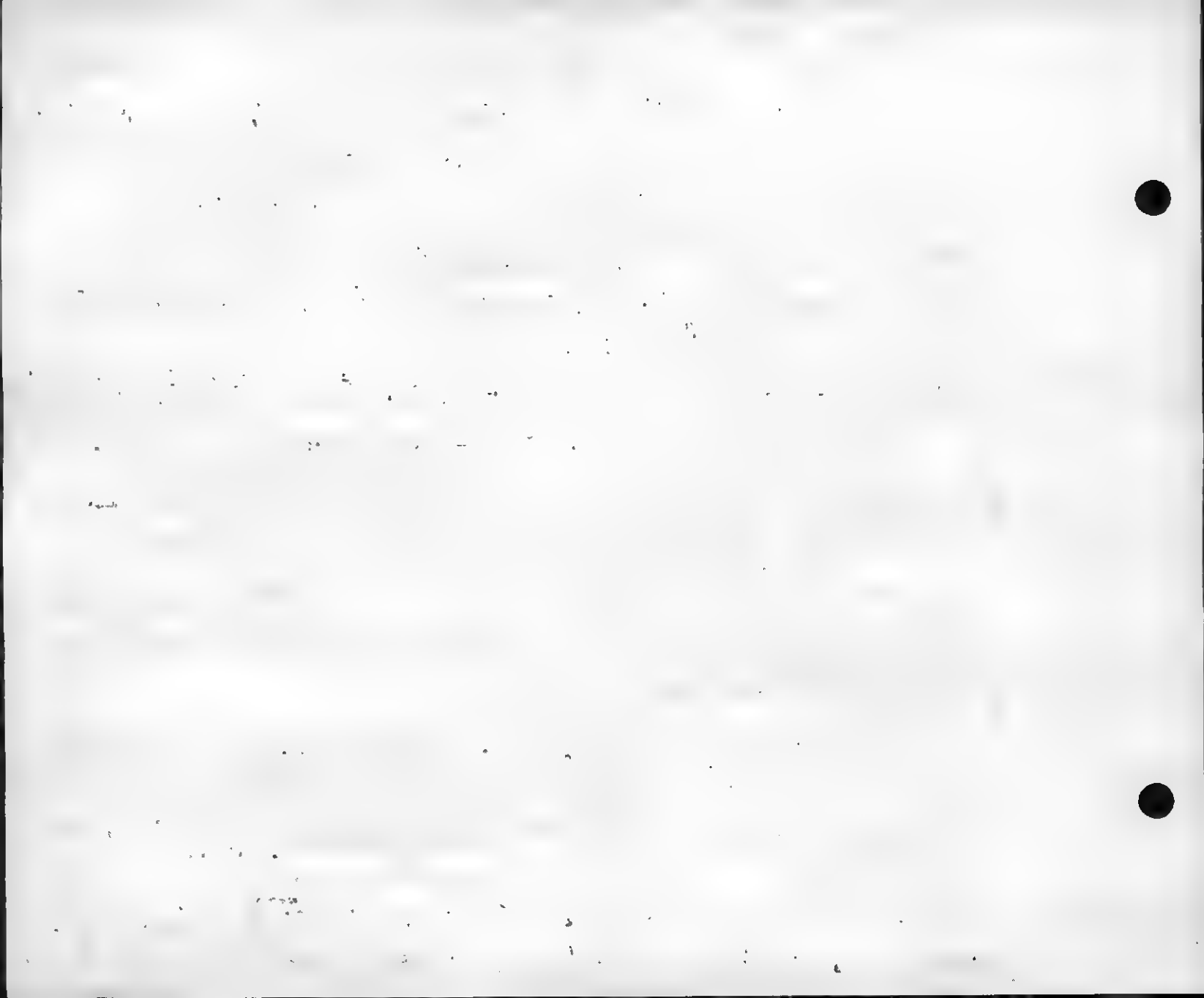
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1/68

MD362
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last FLORENCE A. REIGLE			2a. DATE OF DEATH Month Day Year 4 21 68			2b. HOUR 5 A.M.	
3 SEX F.		4 RACE W.		5. DATE OF BIRTH FEB. 2, 1892		6 AGE (In years lost birthday) 76 YRS	
7a. BIRTHPLACE (State or foreign country) BALTO MD		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 138 CHERRYDELL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales lady		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUA. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 138 CHERRYDELL Rd.		14. FATHER'S NAME First Middle Last John H. ARMEHING		15. MOTHER'S MAIDEN NAME First Middle Last Lillian C. Kimpel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO DIS059258		17. INFORMANT Address GEORGE M. REIGLE 3223 S. 117 STREET OMAHA NEB. 68144			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 411							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 56, to April 19 68, that (I) (we) last saw the deceased alive on March 26 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE - [Signature] Loe J. Gaver				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 22, 1968	
22d. PHYSICIAN'S NAME (Type) Loe J. Gaver				22e. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-24-68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION (City or Town) (County) (State) NORTH AVE BALTO MD.	
24. FUNERAL DIRECTOR DIPPEL BROTHERS INC. 7110 BELAIR Rd				25a. REC'D BY REGISTRAR DATE APR 24 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



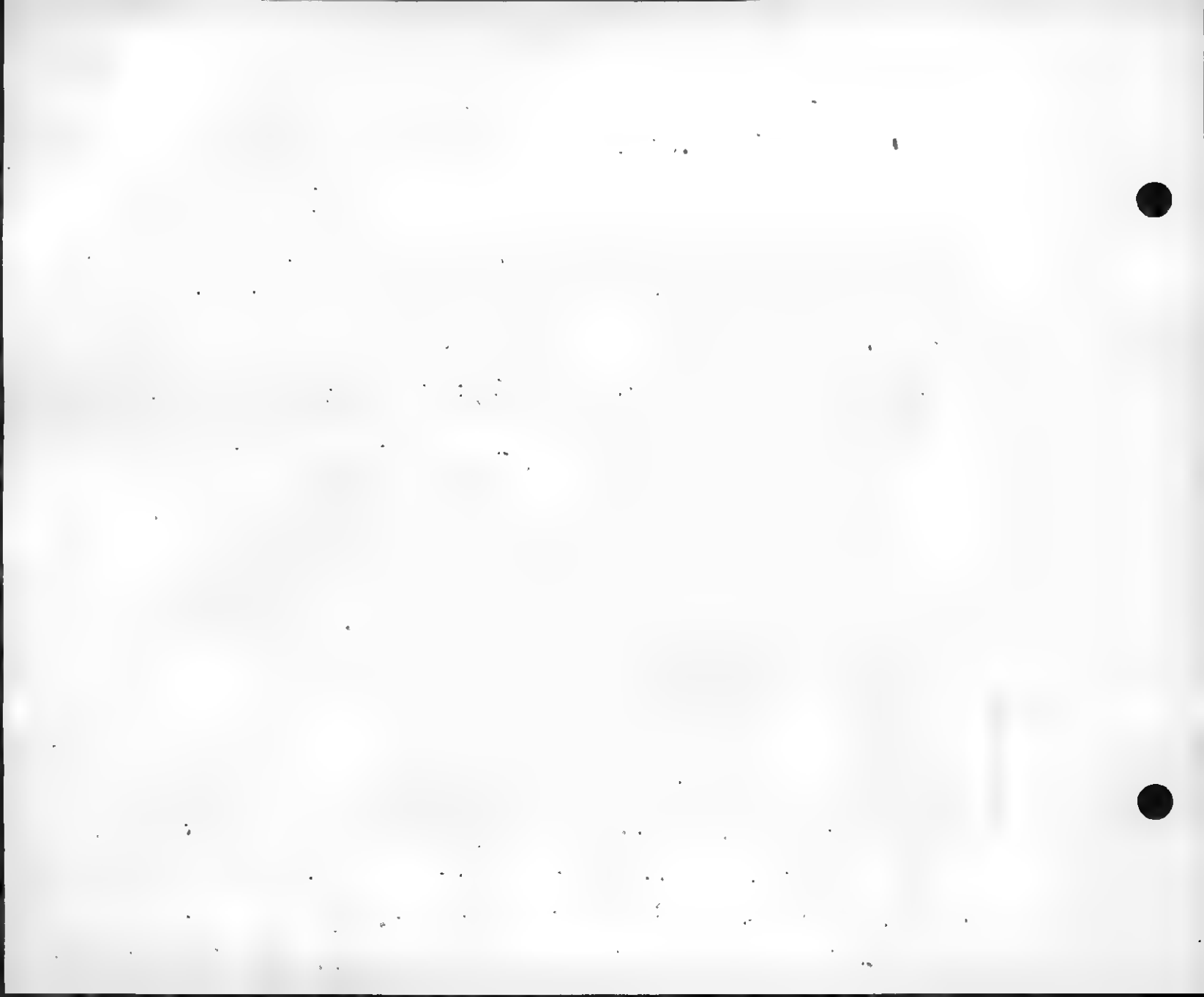
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VR A15 (1)
304 REV 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Nicholas D. RETOS			2a. DATE OF DEATH Month 4 Day 21 Year 68			2b. HOUR M			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 9-1887		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Greece		7b. CITIZEN OF WHAT COUNTRY? Greece		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forest Haven Conv. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Waiter		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7141 Holbird Ave.	
14. FATHER'S NAME First Middle Last Demetre				15. MOTHER'S MAIDEN NAME First Middle Last Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 214-14-2175		17. INFORMANT Mrs. Stella Pappas		Address 7937 St. Gregory, Baltimore Md. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APLMA & MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNUSUAL INSURMINATION DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/7/68 , 19 68 , to 4/21/68 , 19 68 , that (I) (we) last saw the deceased alive on 4/21/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John H. Jones		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) John H. Jones		22e. ADDRESS 5800 Eastern Ave. Baltimore Md.		22c. DATE SIGNED 4/24/68					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-23-68		23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem.		23d. LOCAT ON (City or Town) Baltimore		23e. (County) (State) Md.	
24. FUNERAL DIRECTOR Nicholas T. Matthews				ADDRESS 3021 Eastern Ave Baltimore, Md.		25a. REC'D BY REGISTRAR DATE APR 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



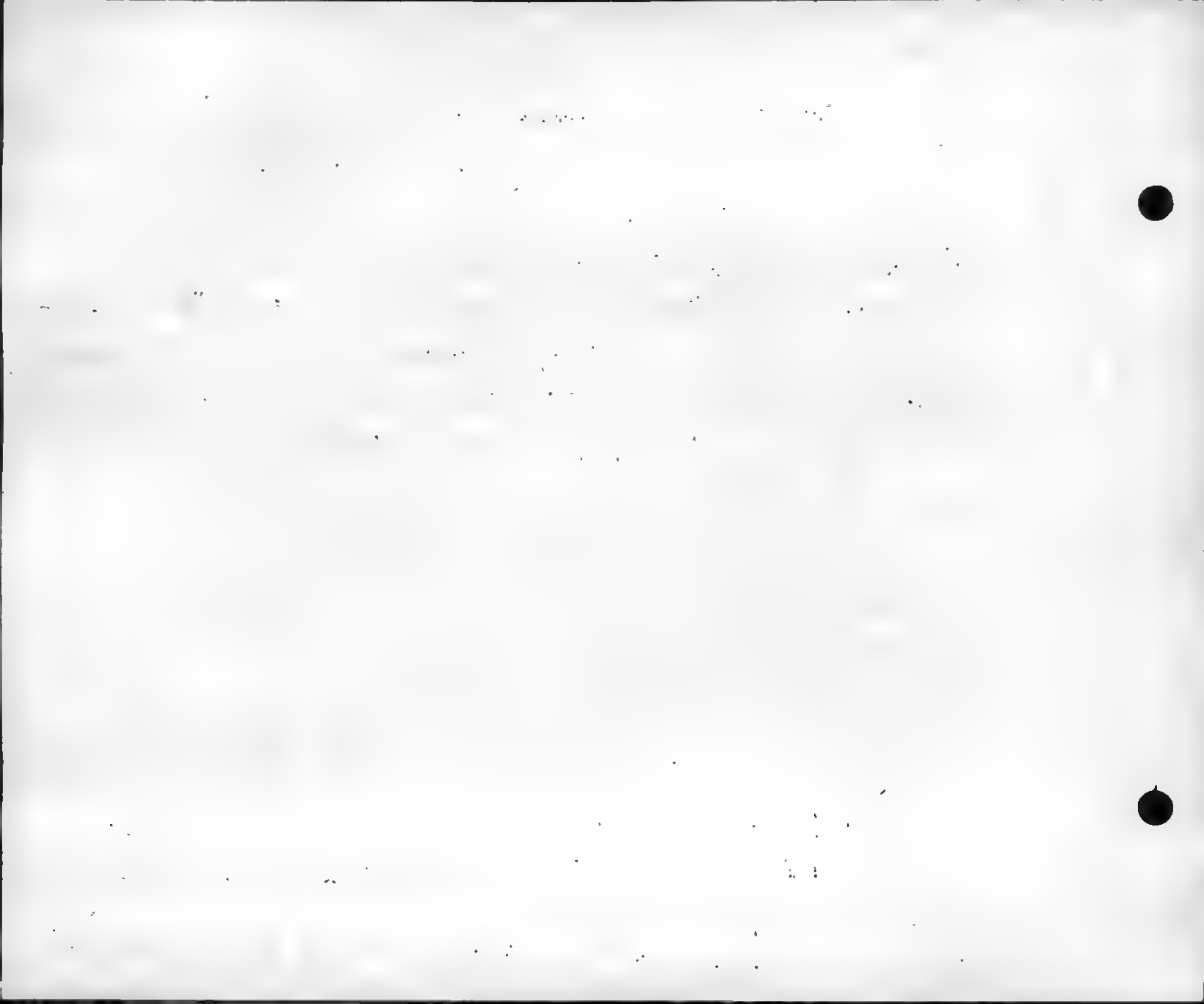
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VR A15
30M REV 1-64

1
58264
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) GERTRUDE B ROBINSON			2a. DATE OF DEATH Month April Day 8 Year 1968			2b. HOUR 10 A M					
3 SEX F		4 RACE W		5 DATE OF BIRTH MAY 26, 1912		6 AGE (In years last b'day) 55 YRS		7 UNDER YEAR MONTHS DAYS 55		8 UNDER 24 HRS. HOURS MIN 55	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 7902 IVY LANE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN 7902 IVY LANE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7902 IVY LANE		
14. FATHER'S NAME First Middle Last MEYER BRAVE			15. MOTHER'S MAIDEN NAME First Middle Last SARAH BRAVE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO 212-16 2484			17 INFORMANT HARRY ROBINSON			Address 7902 IVY LANE		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of breast, metastatic DUE TO, OR AS A CONSEQUENCE OF (b) - DUE TO, OR AS A CONSEQUENCE OF (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170x											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec , 19 65 , to April , 19 68 , that (I) (we) last saw the deceased alive on April 5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Daniel Bakal			22c. DATE SIGNED 4-8-68			22d. PHYSICIAN'S NAME (Type) DANIEL BAKAL, M.D.			22e. ADDRESS 5000 Lochearn Dr, Balto		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4/10/1968			23c. NAME OF CEMETERY OR CREMATORY BETH TILSON			23d. LOCATION (City or Town) (County) (State) BALTO MD		
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc			ADDRESS Garrison, Md			25a. REC'D BY REGISTRAR APR 10 1968			25b. REGISTRAR'S SIGNATURE Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last CHRISTIAN WM. Rodey			2a. DATE OF DEATH Month Day Year 4 9 68			2b. HOUR MIN 210 M	
3 SEX M		4 RACE W		5. DATE OF BIRTH 9/24/1896		6 AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTE Md.	
10. CITY OR TOWN OF DEATH CATONSV. IL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2018 Rollingwood Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. U.S.A. RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE Md		13b. COUNTY BALTE		13c. CITY OR TOWN CATONSV. IL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 2018 Rollingwood Rd		14 FATHER'S NAME First Middle Last CHRISTIAN Rodey		15. MOTHER'S MAIDEN NAME First Middle Last BERTHA WHITUM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 792X IMMEDIATE CAUSE (a) Acute anemia DUE TO, OR AS A CONSEQUENCE OF (b) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 792X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/9, 1968, to 4/9, 1968, that (I) (we) last saw the deceased alive on 4/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert A. Reiter, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/10/68	
22d. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.				22e. ADDRESS 606 Edmondson Ave. 21328			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/12/68		23c. NAME OF CEMETERY OR CREMATORY LORRAINE CEM.		23d. LOCATION (City or Town) (County) (State) BALTE Md.	
24. FUNERAL DIRECTOR E.S. M. Malt				ADDRESS Catonville Md.		25a. REC'D BY REGISTRAR DATE APR 15 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Mary			Middle Roemer			Last Roemer		
2a. DATE KNOWN OF DEATH		DATE ESTIMATED		DATE MONTH		DATE DAY		DATE YEAR		2b. HOUR	
APR 27		1968		5		M					
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		W		7-5-1873		94 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		WIDOWED		DIVORCED	
Maryland		U.S.A.		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Md		St Joseph Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		615 Chesnut Ave.			
14. FATHER'S NAME			First Martin			Middle Roemer			Last Roemer		
15. MOTHER'S MAIDEN NAME			First Margarette			Middle Frey			Last Frey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			214-01-1578			Pickersgill Home			615 Chesnut Ave. 21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				APR 27 1968				Fell out of Bed			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No			
				Home				615 W Chesnut Ave Towson Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				DEPUTY MEDICAL EXAMINER			
Charles F. O'Donnell, M.D.								4/27/68			
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				4/30/68				Western Cemetery			
23d. LOCATION (City or Town)				(County)				(State)			
Baltimore, Md.											
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG STRAR			
Wm. Cook-Brooks Towson 1050 York Rd. 21204								DATE MAY 3 1968			
								25b. REGISTRAR'S SIGNATURE			
								j Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form I-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Robina Meeteer Roeth		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 4/11 1968		2b HOUR 6:00 P.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH 12-25-1884	6 AGE n years (at birthday) 83 YRS	7c DATE PRONOUNCED DEAD Month Day Year April 11 1968
7a BIRTHPLACE (State or foreign country) Chestertown, MD USA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9 COUNTY OF DEATH Baltimore		10 CITY OR TOWN OF DEATH Baltimore		
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5415 Montbel Avenue		12a USUAL RESIDENCE (Kind of work done during most of working life, even if retired.) At Home		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland		13b CITY Baltimore	13c CITY OR TOWN Baltimore	13d INSIDE CITY LIM 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last Charles Rolph		15. MOTHER'S MAIDEN NAME First Middle Last Robina Watkin		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIA. SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT ADDRESS Joseph H. Radcliffe-5415 Montbel Avenue
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma Liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1261 Arteriosclerotic Cardio-Vascular Disease				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE James N. Frederick MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 4/11/68
EXAMINER'S NAME (Type) James N. Frederick MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		1311 Thomas Ave
		ADDRESS (Street, city, town or county) Baltimore		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4-13-68	23c NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Hghts. Ave.		25a REC'D BY REG. STRAR APR 15 1968
		25b REG. STRAR'S SIGNATURE Charles Judge		

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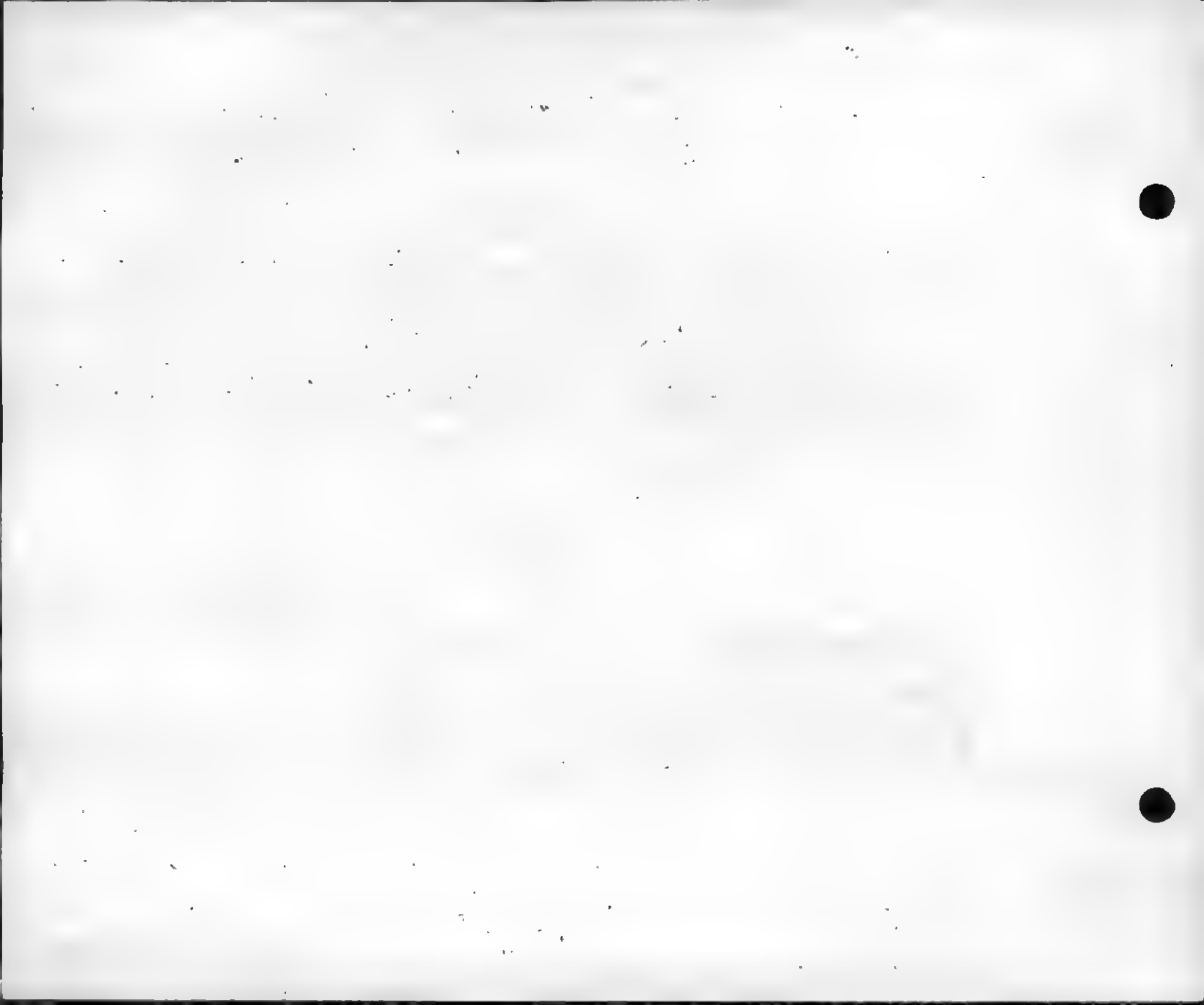
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) LOUIS G ROHNACHER		2a. DATE OF DEATH Month April Day 6 Year 1968		2b. HOUR 5 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH FEB- 3-1919		6. AGE (In years last birthday) 49 YRS.
7a. BIRTHPLACE (State or foreign country) Balto		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH BALTIMORE - COUNTY Md.		10. CITY OR TOWN OF DEATH BALTIMORE - COUNTY		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE - COUNTY		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Funeral Director		12b. KIND OF BUSINESS OR INDUSTRY Funeral
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3521 Rd. Balto 21207
14. FATHER'S NAME First John Middle Rehnacher Last Rehnacher		15. MOTHER'S MAIDEN NAME First Leise Middle Distz Last Distz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 217-05-9429		17. INFORMANT Mrs. Margaret D. Rehnacher Address Balto, Md 21207
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the stomach DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the stomach DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 3-13-1968 , to 4-6-1968 , that (I) (we) lost the deceased alive on 4-6-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Francisco Saez DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED 4-6-68
22d. PHYSICIAN'S NAME (Type) FRANCISCO SAEZ				22e. ADDRESS Baltimore county, James, St. James
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/6/68	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City or town) (County) (State) Woodlawn, Md	
24. FUNERAL DIRECTOR Lening Byars, 8728 Liberty Road		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

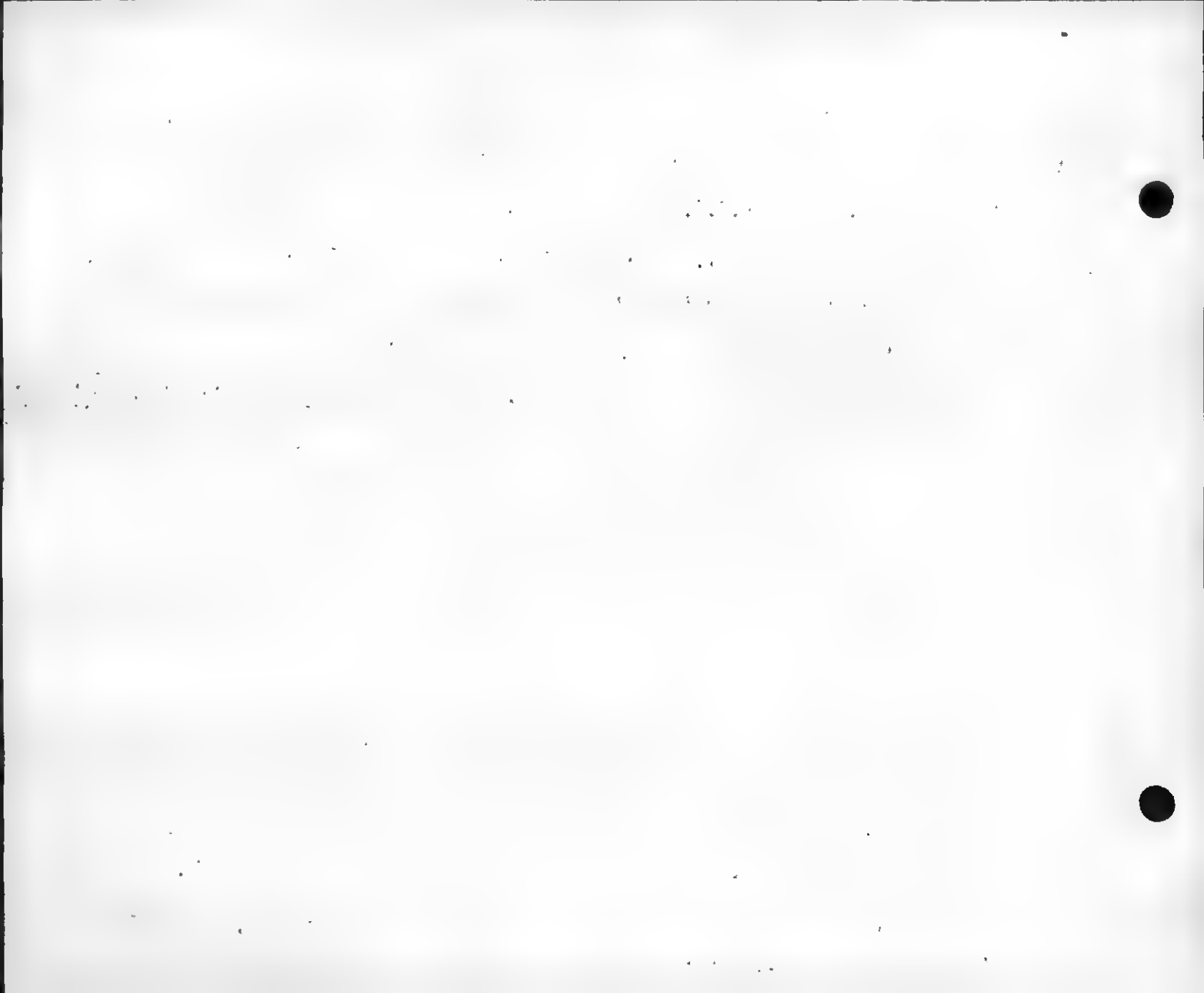


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the health director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ESTHER			ROSE			Month Day Year APRIL 29, 1968			3:45 PM
3 SEX	4 RACE	5. DATE OF BIRTH			6 AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	WHITE	APRIL 16, 1900			68 YRS	MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
BOSTON, MASS.		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		ST. JOSEPH'S HOSPITAL			HOUSEWIFE		AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
MARYLAND			BALTIMORE	PARKVILLE		8410 NUNLEV DRIVE			
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
RUBEN SKLAR			PAULINE ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO					2088 B N. JOHN RUSSEL CIR. MRS. EDITH MAGILNER, LYNWOOD GARDEN PARK, ELKINS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u>								1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								8 yrs	
(b) <u>art sel cv disease</u>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
none									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/12, 1968</u> , to <u>4/29, 1968</u> , that (I) (we) last saw the deceased alive on <u>4/29, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Maurice Feldman MD</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/29/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>MAURICE FELDMAN</u>					22e. ADDRESS <u>6610 CROSS COUNTRY BLVD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL-REMOVAL 4-29-68				LOMBARDY		WILMINGTON DELAWARE			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REG-STRAR		25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					DATE <u>APR 30 1968</u>		<u>J. Charles Judge</u>		



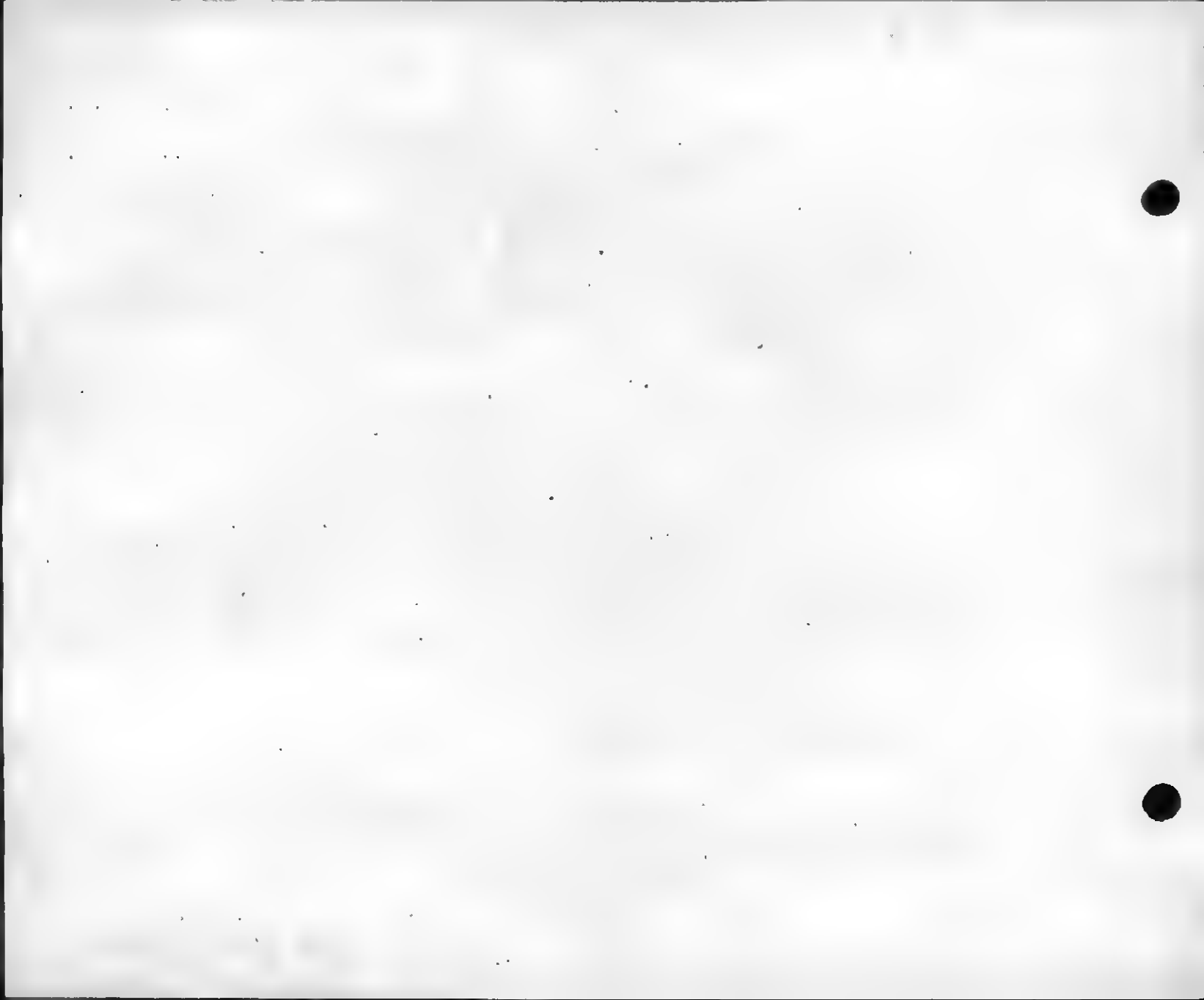
FOR STATE HEALTH DEPT

TO **DEPUTY CHIEF MEDICAL EXAMINER**: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
JAMES JOSEPH ROSSO			April 17, 1968		2P M					
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
Male	White	7/17/1910	57 YRS	MONTHS DAYS		HOURS MIN		Month April Day 17, Year 19 68		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland		USA				Baltimore		Md		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson		St. Joseph's Hospital		Musician						
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland					Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Daybreak 5612 Daybreak Terr.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Salvatore Rosso			Josephine Piraino							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No			215 16 7316		Mrs. Marie M. Rosso- 5612 Daybreak Terr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF										
4/12/0 Cardiac Arrest Sudden										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last 4417 Generalized arteriosclerotic Cardio Renal/Vascular disease while under general anesthesia										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumothorax Pulmonary Emphysema										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
4/17/68			Amputation of Rt Forefoot and bilateral Sympathectomy			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2/Item 18)					
			19		Private					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
Charles F. O'Donnell						4/17/68				
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)				
Charles F. O'Donnell, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/22/68		Holy Redeemer Cem.,		Baltimore, Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck Inc. 5305 Harford Rd. #1A						APR 18 1968		John J. Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Rebecca Aiken Rothman</i>		First <i>Rebecca</i> Middle <i>Aiken</i> Last <i>Rothman</i>		2a. DATE OF DEATH Month <i>April</i> Day <i>14</i> Year <i>1968</i>		2b. HOUR <i>12 P.M.</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>May 28, 1899</i>		6 AGE (in years) YRS. <i>68</i>	
7a BIRTHPLACE (State or foreign country) <i>Poland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i>	
10 CITY OR TOWN OF DEATH <i>Pikesville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Midford Manor Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before death) <i>Baltimore</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>md</i>		13d. INSIDE CITY (Y or N) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME <i>Joseph Pinkner</i>		First <i>Joseph</i> Middle <i>Pinkner</i> Last <i>Pinkner</i>		15 MOTHER'S MAIDEN NAME <i>Yetta</i>		First <i>Yetta</i> Middle <i>Yetta</i> Last <i>Yetta</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Signature Aiken - 4100 Bedford Rd</i>		Address <i>4100 Bedford Rd</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>Feb 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Pancreas</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <i>19</i> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21a. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i> , 19____, to <i>4/15</i> , 19 <i>68</i> , that (I) (was) last saw the deceased alive on <i>4/15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (do not) view the body after death.							
22b. SIGNATURE <i>Milton Kirsh</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-15-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>MILTON KIRSH</i>		22e. ADDRESS <i>4000 Northern Parkway</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 15/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hebrew Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Woodlawn, Md</i>	
24. FUNERAL DIRECTOR <i>Sol Lenson & Sons</i>		ADDRESS <i>2nd - 6010 Keokuk Rd</i>		25a. REC'D BY REGISTRAR DATE <i>APR 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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VR A15
30M REV 1/68

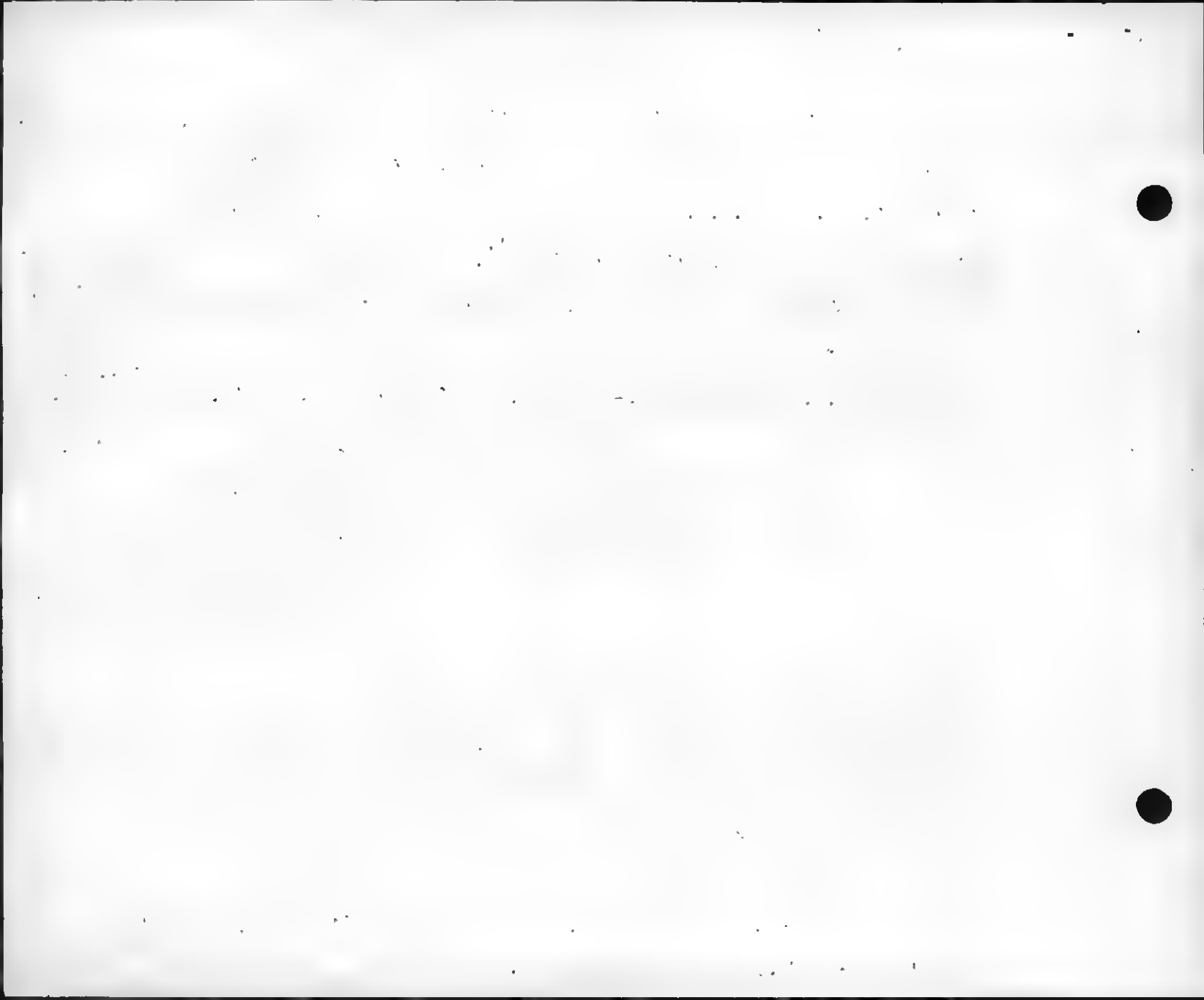
05572

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05374

1. DECEASED-NAME (Type or print) First Middle Last IRVIN NORMAN RUBIN			2a. DATE OF DEATH Month Day Year APRIL 5, 1968			2b. HOUR 2:30A.M.	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH JUNE 7, 1924		6. AGE (In years last birthday) 43 YRS	
7a. BIRTHPLACE (State or foreign country) HARRISBURG, PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH OWINGS MILLS		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) APT. 303 107 ENCHANTED HILL RD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN OWINGS MILLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last HYMAN RUBIN		15. MOTHER'S MAIDEN NAME First Middle Last LENA ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES W.W. II ARMY			
16b. SOCIAL SECURITY NO. 204-03-8870		17. INFORMANT Address MRS. FRANCES RUBIN, 107 ENCHANTED HILLS RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis of coronary arteries							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/4/1968 to 4/4/1968 , that (I) (we) lost saw the deceased alive on 4/4/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Philip Bernstein				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/4/68	
22d. PHYSICIAN'S NAME (Type) PHILIP BERNSTEIN				22e. ADDRESS 112 CHARTLEY DRIVE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-7-68		23c. NAME OF CEMETERY OR CREMATORY (ARLINGTON) CHIZUK AMUNO		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN RD. #15				25a. RECEIVED BY REGISTRAR APR 10 1968			
				25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD 373

05375

05373

05375

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Doris		G.		RUDY	April 1, 1968		6:10AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White		August 31, 1904		63 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland	U.S.A.				Baltimore,			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson	ST. JOSEPH HOSPITAL		Homemaker		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland	Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3713 Delverne Rd.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
James N. Pfeiffer				Elizabeth Humerick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
No				217-09-2244		Daniel W. Rudy, 5536 Rockburn Hill Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal hemorrhage</u> <u>5/1/68</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>bleeding esophageal varices</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>portal cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
MEDICAL CERTIFICATION								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (X) (this hospital) attended the deceased from <u>March 25, 1968</u> , to <u>April 1, 1968</u> , that (X) (we) last saw the deceased alive on <u>April 1, 1968</u> and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Lawrence F. Misanik</u>						22c. DATE SIGNED April 1, 1968		
22d. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.						22e. ADDRESS 7620 York Rd., Towson, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/4/68		Loudon Park		Baltimore, Md.		
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Baltimore, Md.		25a. REC'D BY REGISTRAR DATE APR 3 - 1968		25b. REGISTRAR'S SIGNATURE <u>Francis J. Judge</u>



2

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00374

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. NAME OF DECEASED

(Type or Print)

August Russo

2. DATE AND HOUR OF DEATH

4-29-68

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

Baltimore County

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Chesapeake Manor Nursing Home
509 E. Joppa Road, Balto. Md.
21204

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3108 Weaver Avenue, 21214

5. SEX

Male

6. RACE

White

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Oct 16 1875

9. AGE (In years
last birthday)

92

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bartender

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Carmello Russo

14. MOTHER'S MAIDEN NAME

Salvatora Russo

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no, or unknown) If yes, give war or dates of service

No

16. SOCIAL
SECURITY NO.

218 32 3875

17. INFORMANT

ADDRESS

A Marie S. Young, 3108 Weaver Ave. 21214

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

(B)

DUE TO, OR AS A CONSEQUENCE OF

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A)

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on

4-29

1968

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Sebastian Russo

Attending
Phys.

Med.
Director ☐

Staff
Phys ☐

23B. DATE SIGNED

5/1/68

23C. PHYSICIAN'S
NAME (Type)

Dr. Sebastian Russo

23D. ADDRESS

5017 Harford Road, Balto. Md. 21214

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-2-68

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

VR A1525A. DATE REC'D BY HEALTH DEPT.
30M REV

MAY 6 1968

25B. NAME OF REGISTRAR

Wm. E. Johnson

25C. FUNERAL DIRECTOR

Wm. E. Johnson 8521 Loch Raven Blvd, 21204

ADDRESS

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ATION



FOR STATE HEALTH DEPT.

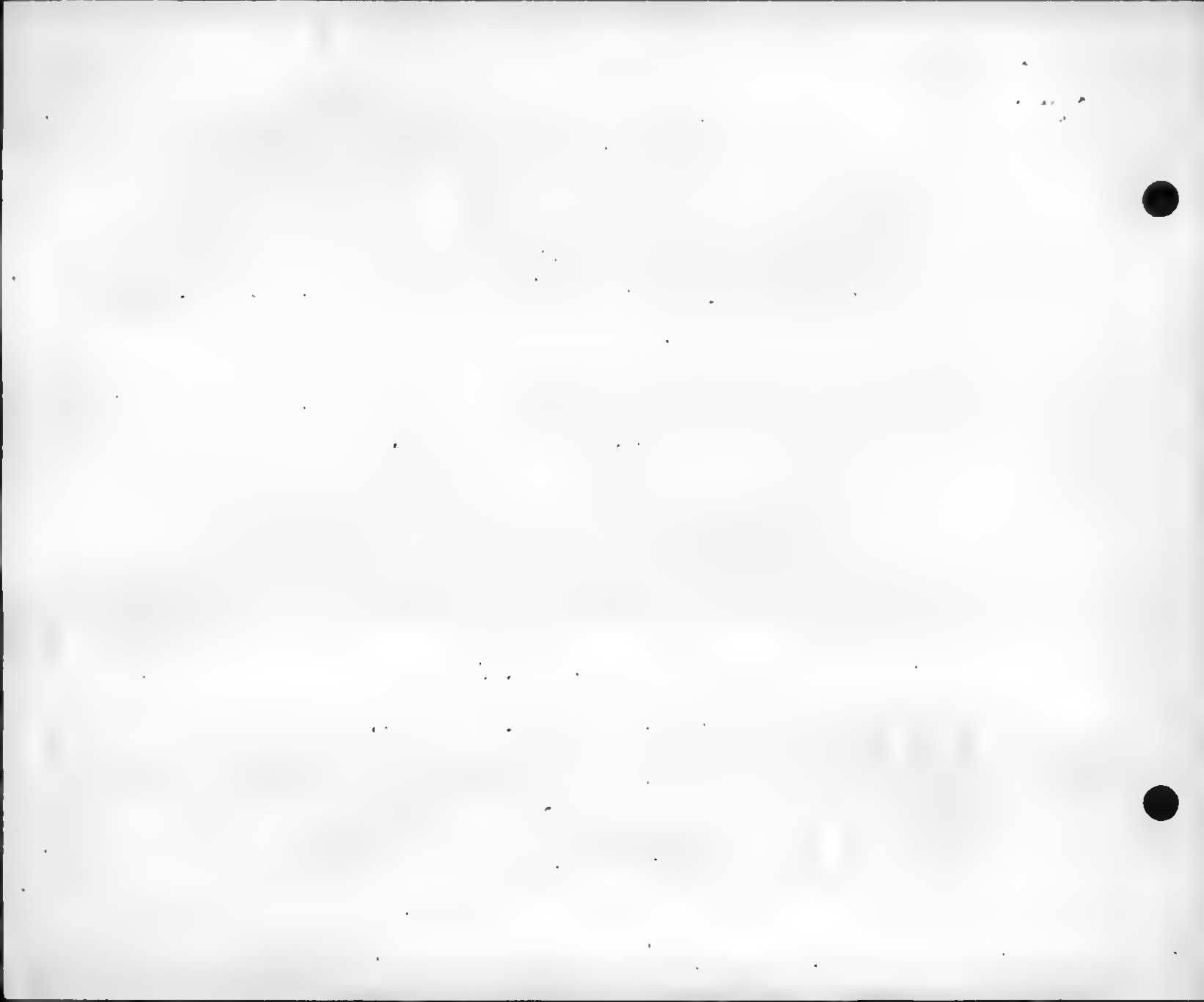
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Margaret V. Ryan			2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> Month 4 Day 26 Year 1968			2b. HOUR 6:40 PM			
3 SEX F	4 RACE W	5 DATE OF BIRTH 2-23-1912	6 AGE (In years last birthday) 56 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	7 UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 4 Day 26 Year 1968			2d. HOUR 6:40 PM
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY Charles		13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Indian Head, Md. Spring Grove Hosp.		
14. FATHER'S NAME First John Middle C. Last Ryan			5. MOTHER'S MAIDEN NAME First Cecelia Middle Boswell Last Baswell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO NONE		17. INFORMANT Dr. F. Guzman ADDRESS Spring Grove Hosp.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation by Aspiration									Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
9217									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 4/26 1968 HOUR AM 5:00		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Aspirated Fish Cake at Dinner				
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Spring Grove Hosp		21f. LOCATION Street or RFD No Catonsville City or Town Balto. County Md State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James N. Frederick M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/26/68			
EXAMINER'S NAME (Type) James N. Frederick			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) 1311 Francis Ave Balto. Md 21222						
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE May 3, 1968		23c. NAME OF CEMETERY OR CREMATORY FISGAH Methodist		23d. LOCATION (City or Town) FISGAH (County) Chas (State) Md			
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf Md			25a. REC'D BY REGISTRAR WAY DATE 6 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

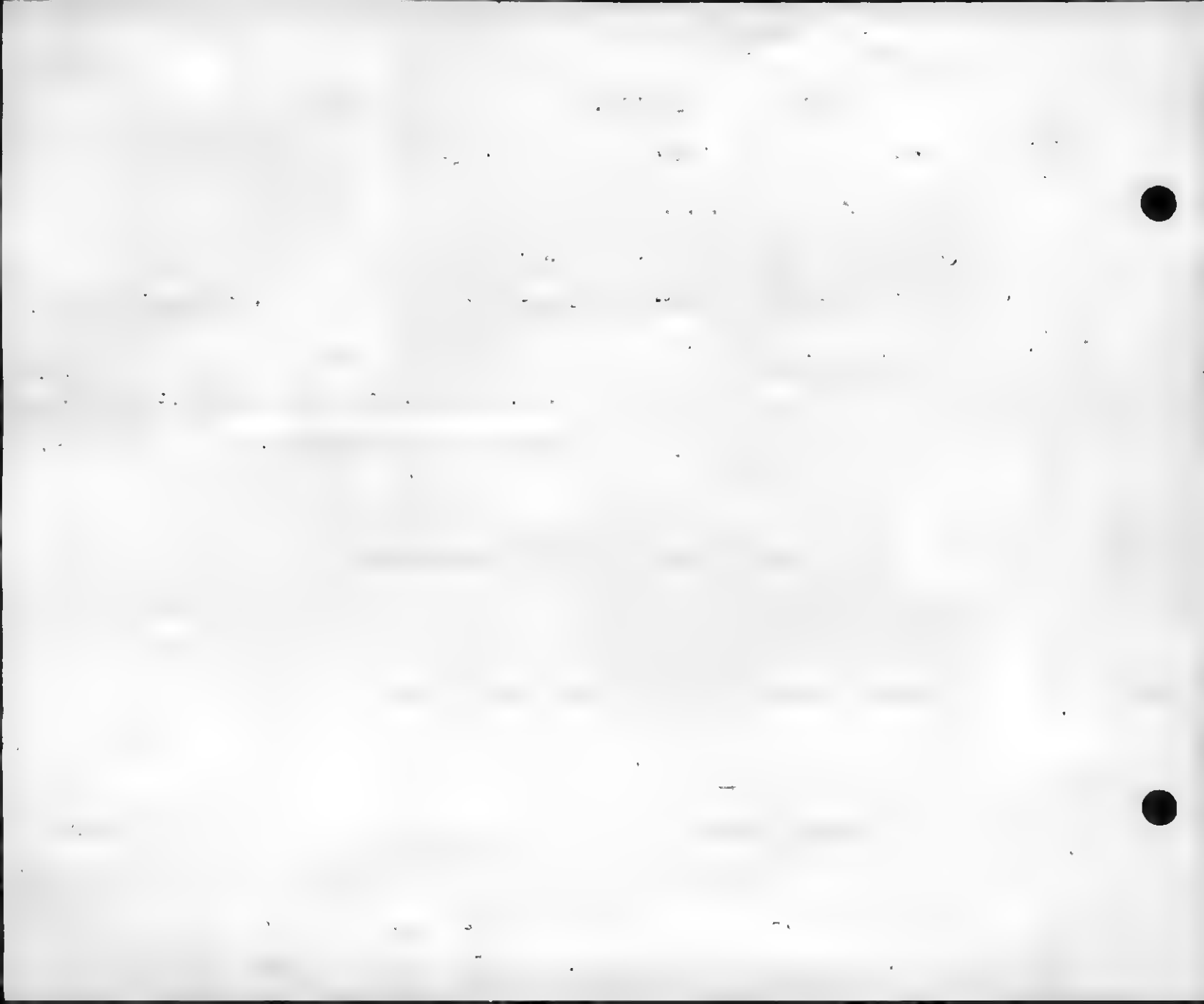
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1 (4)
304 REV. 6-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EDITH		First EDITH		Middle SANTMYER		Last		2a. DATE OF DEATH April Month 14 Day 1968 Year				2b. HOUR M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 7-12-1915				6 AGE (In years last birthday) 52 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md							
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 931 Southridge Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if instituton: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 931 Southridge Road					
14. FATHER'S NAME First Paul Middle J. Last Belschner				15. MOTHER'S MAIDEN NAME First Rose Middle Werntz Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Mr. James E. Santmyer, 931 Southridge Rd.				Address 21228					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma of left breast DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170x													
19a. DATE OF OPERATION 30 Nov 59		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED breast mass				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 25 November, 1959 , to 14 April, 1968 , that (I) (we) last saw the deceased alive on 8 April, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. Irwin H. Moss, MD				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 15 April 68					
22d. PHYSICIAN'S NAME (Type) Dr. Irwin H. Moss				22e. ADDRESS Westview Shopping Center, Catonsville, Md									
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-17-1968		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

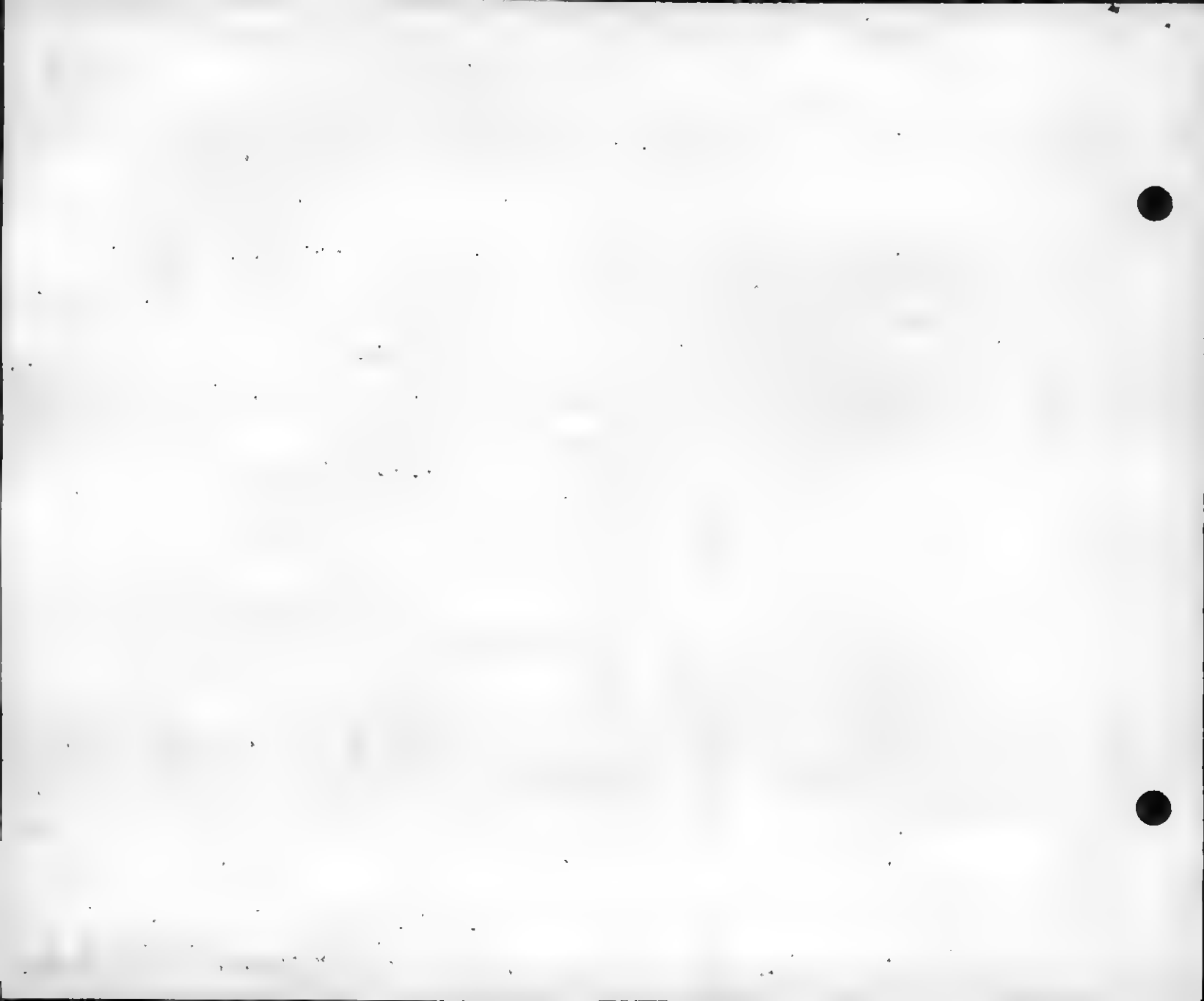
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VR 115
30M REV 10

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) ANNA		First	Middle	Last	2a. DATE OF DEATH Month APRIL Day 19 Year 68			2b. HOUR 3 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH			6. AGE (In years lost birthday) 80 YRS	IF UNDER 12 MONTHS	IF UNDER 1 YEAR	IF UNDER 24 HRS
7a. BIRTHPLACE (State or foreign country) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY Md				
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) BALTIMORE COUNTY GEN HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 22 WARREN PARK RD		
14. FATHER'S NAME First ? Middle XXXXXX Last KUSHINCK		15. MOTHER'S MAIDEN NAME First ? Middle HINDA Last ?			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT MR. RAYMOND SCHAPIRO			Address APT. C-1 #15 3505 CLARKS LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF CARDIOVASCULAR Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from April 6, 1968 to April 9, 1968 , that (I) (we) last saw the deceased alive on April 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Josefina T. Naraval MD DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED April 19, 1968			
22d. PHYSICIAN'S NAME (Type) JOSEFINA T. NARAVAL					22e. ADDRESS BALTO. COUNTY GEN HOSP			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-21-68		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH (AITZ CHAIM)		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. ADDRESS 6010 REISTERSTOWN ROAD, BALTO. 21215					25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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55378
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #12, 13, c, d & e infor. taken from birth cert

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) INFANT			First INFANT			Middle FEMALE			Last SCHEK			2a. DATE OF DEATH 4 Month 7 Day 68 Year				2b. HOUR 2:30P M	
3. SEX Female			4. RACE White			5. DATE OF BIRTH			6. AGE (In years last birthday) YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore, Md								
10. CITY OR TOWN OF DEATH Towson, Maryland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Lutherville			3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 20 Dunwick Rd.					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hyaline Membrane Disease 7761 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Prematurity - 26 weeks DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7735															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from April 7, 1968 , to April 7, 1968 , that (I) (we) lost saw the deceased alive on April 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Rudiger Breitenecker</i>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED April 8, 1968								
22d. PHYSICIAN'S NAME (Type) RUDIGER BREITENECKER, M.D.			22e. ADDRESS Greater Baltimore Medical Center														
23a. BURIAL, CREMATION, REMOVAL. (Specify) Cremation			23b. DATE 4/8/68			23c. NAME OF CEMETERY OR CREMATORY Greater Balto. Med. Cen.			23d. LOCATION (City or Town) (County) (State) Towson, Maryland								
24. FUNERAL DIRECTOR <i>Rudiger Breitenecker</i>			ADDRESS GBMC			25a. REC'D BY REGISTRAR DATE APR 11 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

Item # 14, Film # G401 5/31/68 km

1. DECEASED NAME (Type or print) First Middle Last Mildred Edna Scherer			2a. DATE OF DEATH Month Day Year 4 17 68			2b. HOUR 4 a M	
3. SEX Female		4. RACE Cau		5. DATE OF BIRTH 11/16/11		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto Med. Center		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY USA	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2003 Northbourne Rd.							
14. FATHER'S NAME First Middle Last Richard E. P. Waite			15. MOTHER'S MAIDEN NAME First Middle Last Emma E. Aring				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. John W. Scherer (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 180X DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent carcinoma of cervix uteri Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 171X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/1 , 19 68 , to 4/1 , 19 68 , that (I) (we) lost saw the deceased alive on 4/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE John E. Adams		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/17/68			
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.		22e. ADDRESS 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/20/68.		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR APR 17 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	

MEDICAL CERTIFICATION



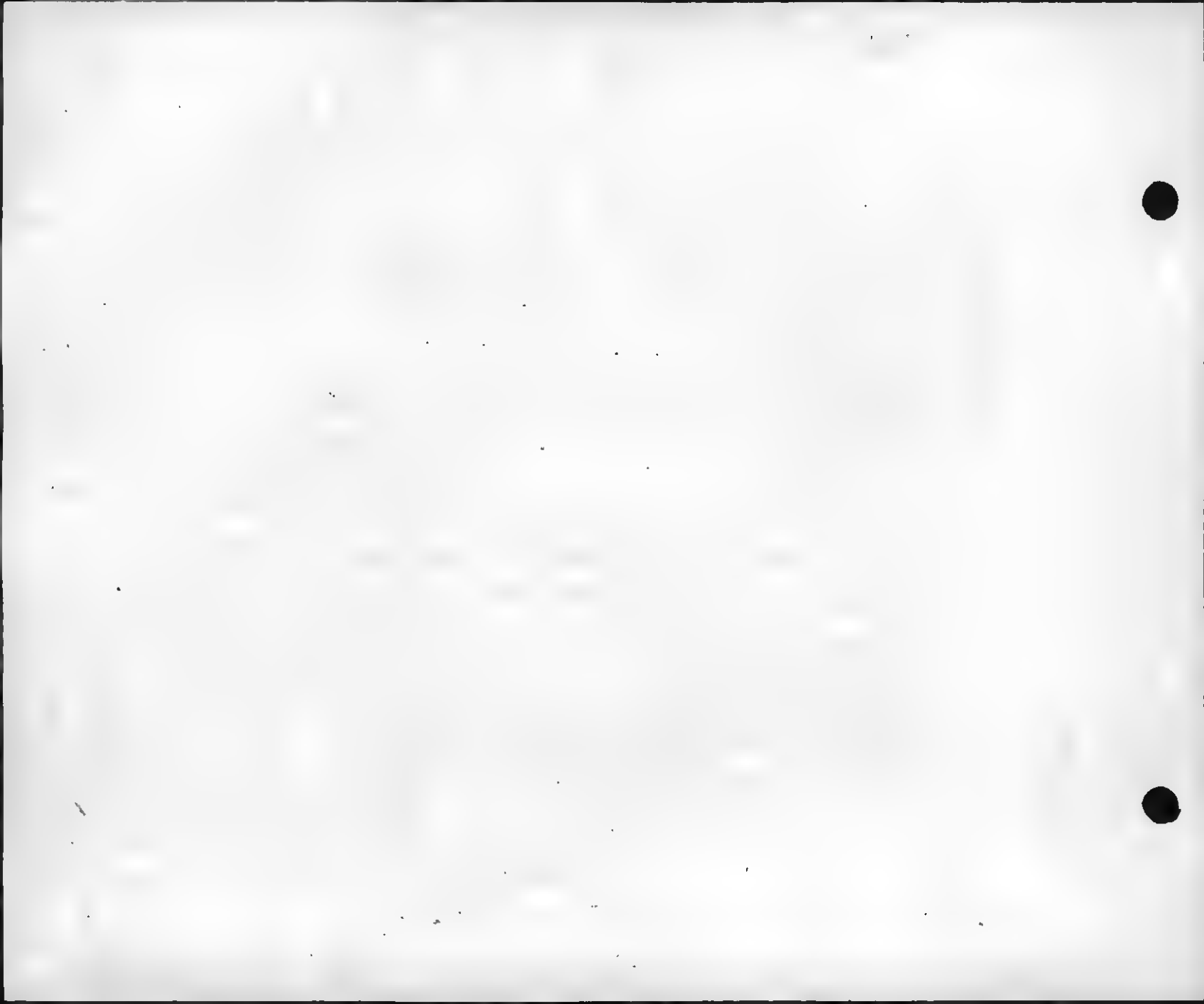
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>Clara (NMN) Schmidt</i>			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year <i>4/10 1968</i>			2b. HOUR OF ESTI MATED DEATH <i>4:15 P M</i>		
3 SEX <i>F</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>11/17/87</i>	6 AGE (In years last birthday, <i>80 YRS</i>)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	F UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>10</i> Year <i>1968</i>		2d. HOUR <i>4:15 P M</i>
7a. BIRTHPLACE (State or foreign country) <i>Farmington, N.H.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> UNMARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.		
10 CITY OR TOWN OF DEATH <i>Bandallstown</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Balto. Co. Gen. Hosp. office Bldg.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <i>Washinghouse</i>		
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto</i>	13c. CITY OR TOWN <i>Bandallstown</i>	13d. NEARBY CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>Robson & Liberty Road.</i>		
14 FATHER'S NAME First <i>Quotar</i> Middle <i>Schmidt</i> Last <i>Schmidt</i>			15 MOTHER'S MAIDEN NAME First <i>Angeline</i> Middle <i>Monted</i> Last <i>Oro</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO <i>579-16-9223</i>		17 INFORMANT <i>Marion H. Schmidt</i> ADDRESS <i>9506 Liberty Road.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Second & Third Degree Burns</i> <i>891X</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <i>85% Body Surface</i> (c) <i>4 days</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Previous Radical Mastectomy - Left. - 2 yrs ago.</i>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>10:30 P M</i> <i>4/6 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Bed set on fire by patient at Nursing Home - CHADEL HILL NURSING-HOME</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Nursing Home</i>		21f. LOCATION Street or R.F.D. No. <i>Robson & Liberty Rd.</i> City or Town <i>Bandallstown</i> County <i>Balto</i> State <i>Md.</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James N. Frederick</i> EXAMINER'S NAME (Type) <i>James N. Frederick</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>4/10/68</i> <i>1311 Francis Ave</i> <i>Balto, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-13-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wm. Hope Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Cesce, Wis.</i>		
24. FUNERAL DIRECTOR <i>Erving Byers</i> ADDRESS <i>8728 Liberty Road</i>				25a. REC'D BY REG STRAR <i>APR 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-14 (4)
30M REV. 1/68

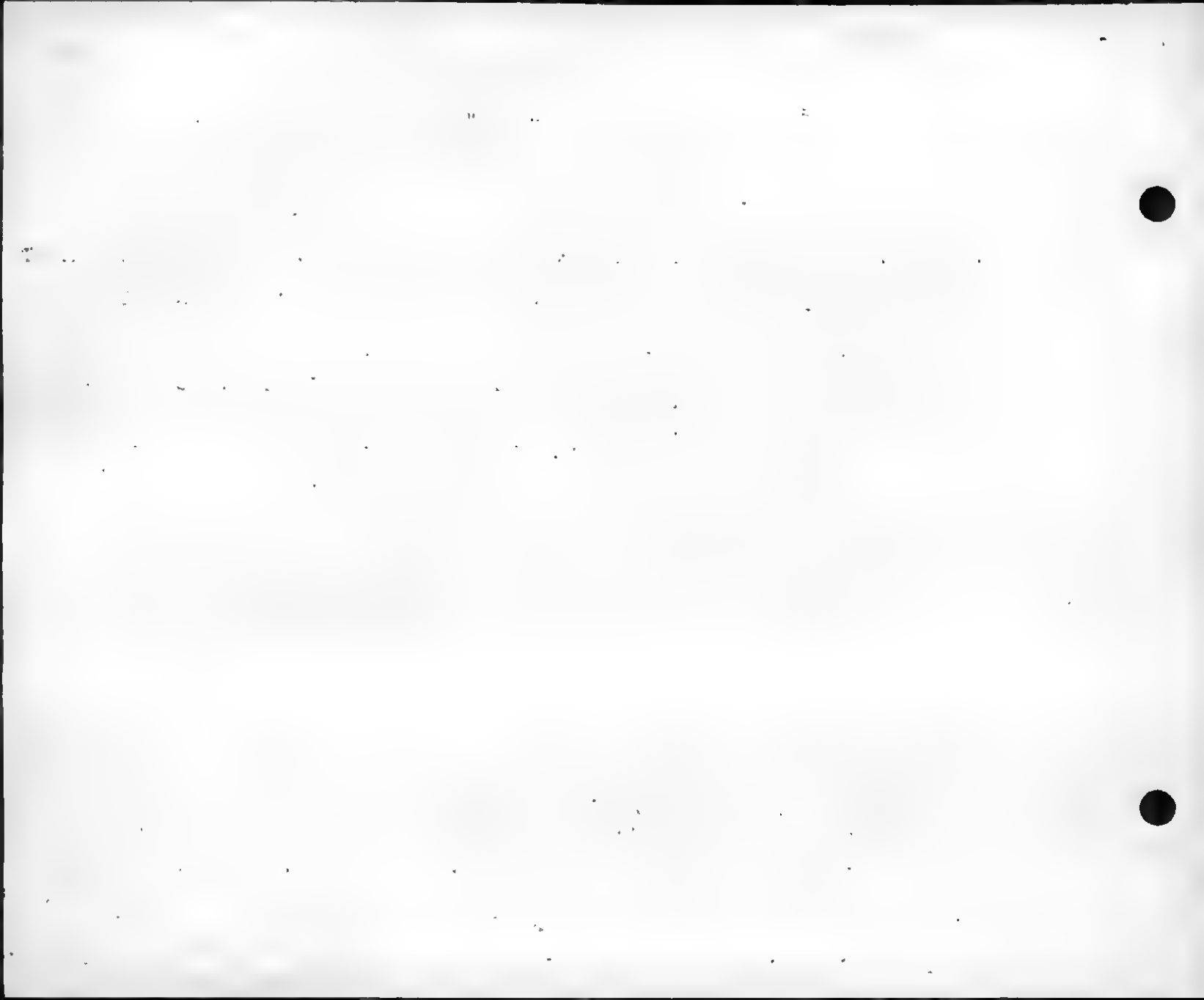
<div>33381</div> <div> <div>MD</div> <div> <div>33</div> <div>33</div> </div> </div>											
1 DECEASED NAME (Type or print) Theresa S. SCHMIDT						2a DATE OF DEATH Month April Day 24 Year 1968			2b HOUR 7:30AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH December 7, 1915			6 AGE (In years lost birthday) 52 YRS.		7 IF UNDER YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.					
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b COUNTY Timonium		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 1911 Lyden Rd. 21093			
14. FATHER'S NAME First Henry Middle J. Last Slagle				15. MOTHER'S MAIDEN NAME First Sophia Middle M. Last Kabehlein							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)				16b SOCIAL SECURITY NO.		17 INFORMANT Address Mr Henry W. Schmidt 1911 Lyden Road 21093					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive brain hemorrhage 4309 DUE TO, OR AS A CONSEQUENCE OF (b) rupture of berry aneurysm of left communicating artery DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that to (this hospital) attended the deceased from 4/23/ , 19 68 , to 4/24/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/24/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Reynaldo Orjuela-Gomez, M.D.						22c. DATE SIGNED April 24, 1968		22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.			
22e. ADDRESS 7620 York Rd., Towson, Md. 21204											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-27-1968			23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR Massahn Funeral Home 7401 Delair Road 21236						25a. REC'D BY REGISTRAR APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

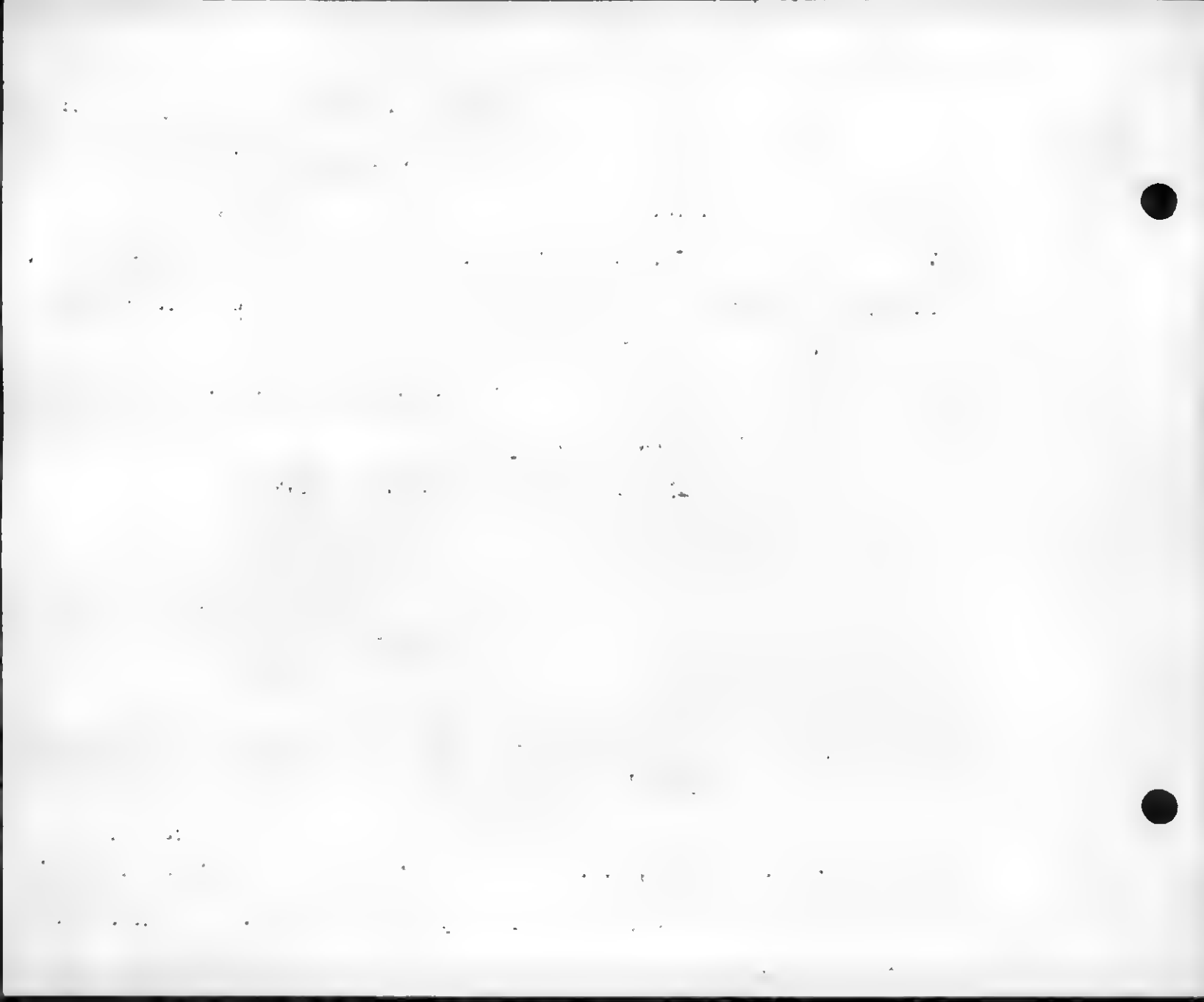
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR 25 AM		
MANUEL			SCHNIDER			APRIL 7, 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR		
MALE		WHITE		JULY 31, 1894		73 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
RUSSIA		U.S.A.				BALTIMORE				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
RANDALLSTOWN		BALTO. CO. GEN. HOSP.				MERCHANT		INSTALLMENT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE				6801 PARK HGHTS. AVE.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
MAISHE SCHNIDER			SARAH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			216-01-2951A		MRS. MINNIE SCHNIDER 6801 PARK HEIGHTS AVE. #21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> 3 years										
1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										
(d) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
1. _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11-3, 1967, to 4-7, 1968, that (I) (we) last saw the deceased alive on 4-7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph C. Matchar</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 4/8/68					
22d. PHYSICIAN'S NAME (Type) <u>K. JOSEPH MATCHAR</u>					22e. ADDRESS 6821 REISTERSTOWN ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4-8-68		BETH EL MEMORIAL PARK		RANDALLSTOWN, MD.				
24. FUNERAL DIRECTOR ADDRESS RD. 52a. REC'D BY REGISTRAR					25a. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS., 6010 REISTERSTOWN					DATE APR 10 1968		<u>William J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death
 Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
HOWARD			SCHROTH Sr.			APRIL 27, 1968			3:55 AM		
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
MALE			WHITE			NOVEMBER 5, 1903			64 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			U.S.A.			BALTIMORE, Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL						GAS & ELEC.		
13a. USUAL RESIDENCE (Where deceased lived, f admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MARYLAND			BALTIMORE						3123 TEXAS AVE. #21234		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Charles Schroth			unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			212-75-4553			Mr Howard A. Schroth Jr.			21227 L.D. Elder Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from APRIL 15, 1968, to APRIL 27, 1968, that (X) (we) lost saw the deceased alive on APRIL 27, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE									22c. DATE SIGNED		
EDUARDO MONTELIBANO, M.D.									APRIL 27, 1968		
22d. PHYSICIAN'S NAME (Type)									22e. ADDRESS		
EDUARDO MONTELIBANO, M.D.									7620 YORK ROAD TOWSON, MD. #21204		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			4-30-1968			St. John's Cemetery			Parkville Balto. Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Lassahn Funeral Home 7401 Belair Road 21204									25b. REGISTRAR'S SIGNATURE		
									APR 29 1968		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

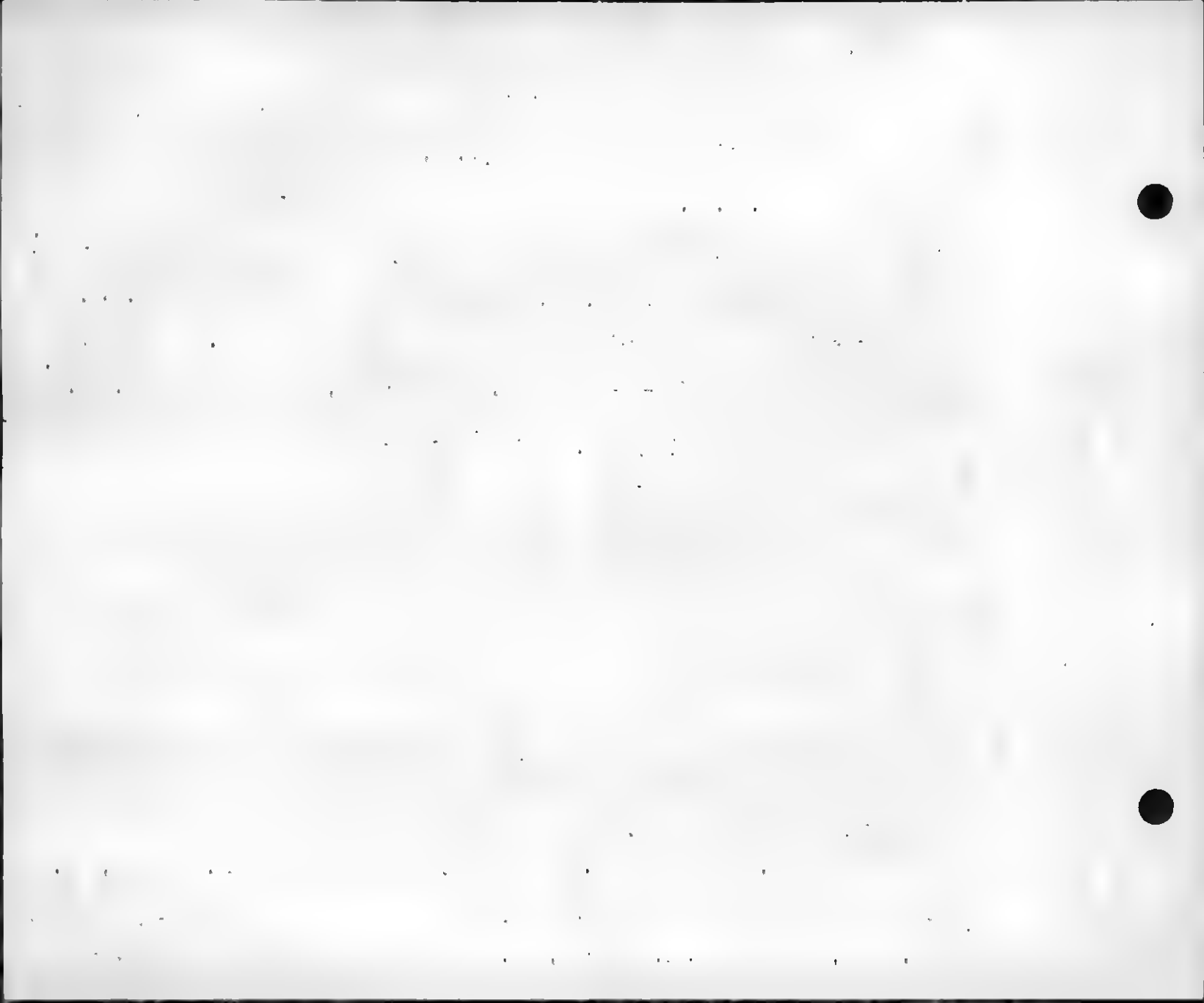
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR 4:25 P	
Lena				Seidel	April 20 1968			
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 24 HRS	
Female	White		Sept. 4, 1887		80 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U. S. A.				Baltimore		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Dundalk		711 Old North Point Road		Machine Operator-Continental Can				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Maryland		711 Old North Pt.		Rd. Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		711 Old North Pt. Rd.
14. FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?		16b SOCIAL SECURITY NO		17 INFORMANT
First Middle Last		First Middle Last		Yes, no, or unknown (If yes give war or dates of service)		215-01-8357		(Sister) Mrs. Ida Filliaux, 711 Old North Pt. Rd.
Frederick		Porsinger		Mary S. Walton				Dundalk, Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410.0 DUE TO, OR AS A CONSEQUENCE OF C. V. R. Disease 20 years								
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/18, 1968, to 4/20, 1968 that (I) (we) last saw the deceased alive on 4/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE Morris A. Jacobs M.D. DEGREE						22c DATE SIGNED 4/22/68		
22d PHYSICIAN'S NAME (Type) Morris A. Jacobs M.D.						22e ADDRESS 1010 Old North Point Rd. Dundalk, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		4/24/68		Oak Lawn Cemetery		Baltimore, Maryland		
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a REC'D BY REGISTRAR DATE APR 24 1968		25b REGISTRAR'S SIGNATURE Charles J. Jager		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 5385

MD 5385

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last CARL WILHELM SEILER			2a. DATE OF DEATH Month Day Year April 5 1968			2b. HOUR 4:20 PM	
3. SEX M		4. RACE Cau		5. DATE OF BIRTH 2/21/89		6. AGE (In years last birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) GERMANY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Greater Baltimore Med. Center		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USJA. RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13e. STREET AND NUMBER 1218 Walker Ave	
14. FATHER'S NAME First Middle Last Baltasar C Seiler			15. MOTHER'S MAIDEN NAME First Middle Last Zimmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-10-0345		17. INFORMANT Address FREDA SEILER 1218 WALKER AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4120 Arteriosclerotic and hypertensive DUE TO, OR AS A CONSEQUENCE OF (b) cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3-4, 1968, to 4-5, 1968, that (I) (we) lost saw the deceased alive on 4-5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James A. DeCastro						22c. DATE SIGNED 4-5-68	
22d. PHYSICIAN'S NAME (Type) Dr. J.A. DeCastro						22e. ADDRESS BMC	
23a. BURIAL, CREMATION, REMOVAL, ETC. Buried		23b. DATE 4-8-68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md. Baltimore	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204				25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

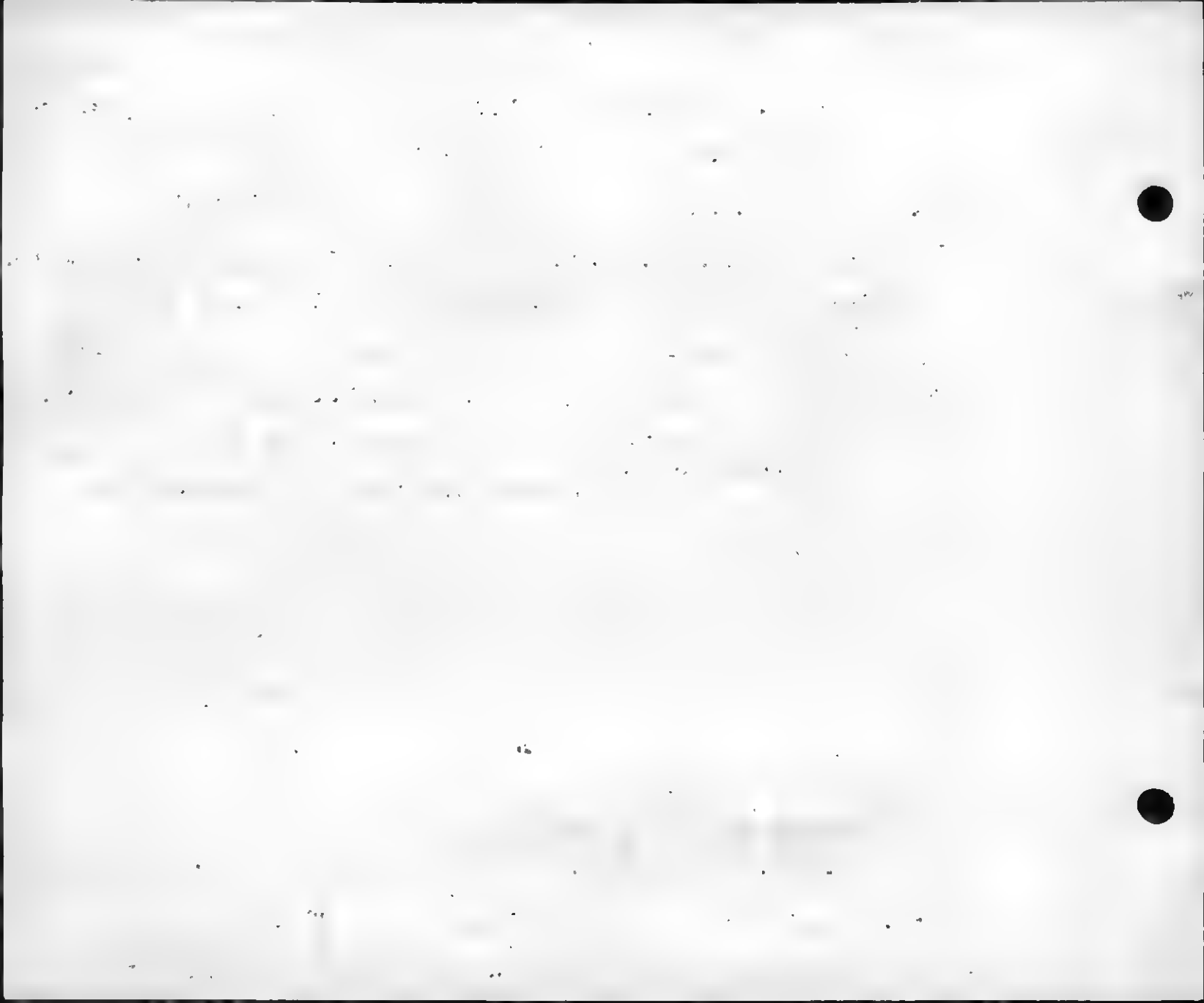


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4-54-1
30M REV. 1/68

<div style="text-align: center;"> <p>5- 1</p> <p>05386</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> <p style="text-align: right;">05386</p> </div>													
1. DECEASED-NAME (Type or print)			First WILLIAM		Middle CHARLES		Last SEITZ		2a. DATE OF DEATH Month April Day 30 Year 1968		2b. HOUR 4:55 P.M.		
3 SEX MALE			4 RACE WHITE			5 DATE OF BIRTH 1/11/88			6 AGE (In years last birthday) 80 YRS		F UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE COUNTY, Md				
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) VET. ADM. HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SPLICER TESTER			12b KIND OF BUSINESS OR INDUSTRY TELEPHONE CO.				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b COUNTY BALTIMORE			13c CITY OR TOWN BALTIMORE			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1558 GALENA ROAD		
14 FATHER'S NAME First HENRY			Middle SEITZ			Last SEITZ			15 MOTHER'S MAIDEN NAME First MARY			Middle HAMILTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) WW I			16b SOCIAL SECURITY NO 212 20 87 05			17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT UPPER LOBE OF LUNG 1621 DUO OF AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE WITH DECOMPENSATION DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO AUTOPSY				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that the (this hospital) attended the deceased from 3/4/68 , 19__, to 4/30/68 , 19__, that it (we) last saw the deceased alive on 4/30/68 , 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) (did) (did not) view the body after death.													
22b SIGNATURE Ahmed Kutty MD								DEGREE M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 5/1/68	
22d PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D.								22e ADDRESS VAH FORT HOWARD, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 5/3/68		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR Frederick D. Miller			ADDRESS 3019 E. Monument Street,			25a RECD BY REGISTRAR MAY 2 1968			25b SIGNATURE Frederick D. Miller				

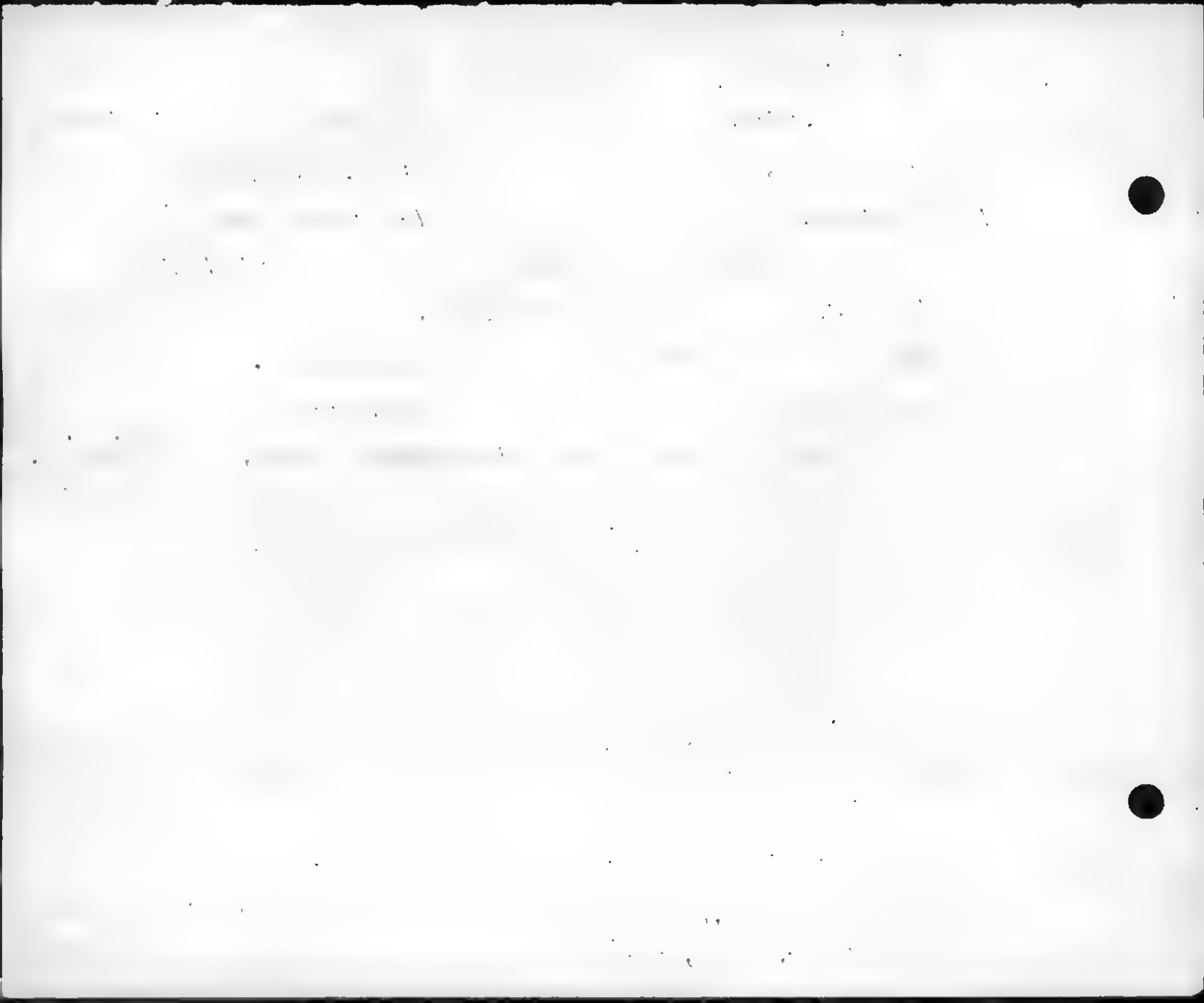


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Providence (Towson 21204)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Providence (Towson 21204)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1000 Roxleigh Road</u>		d. STREET ADDRESS <u>1000 Roxleigh Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Carson</u> Last <u>Shepard</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1875</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph McCall</u>	
14. MOTHER'S MAIDEN NAME <u>Maria Lambert</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>086-07-38300</u>		17. INFORMANT <u>Miss Elizabeth Shephard</u> Address <u>Towson, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>May, 1965</u> to <u>April, 1968</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1968</u> , and that death occurred at <u>2 a.m.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Francis T. Daly</u>		22b. DATE SIGNED <u>4/19/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS T. DALY</u>		22d. ADDRESS <u>3201 N. CHARLES ST</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial April 22, 1968</u>		23b. DATE THEREOF <u>April 22, 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Charlotte, North Carolina</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 23 1968</u>	



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05388

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Emma M. Sherman			2a DATE OF DEATH Month Day Year April 7 68			2b HOUR 6.00PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 4-25-1895		6 AGE (In years last birthday) 72 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last Lund		15 MOTHER'S MAIDEN NAME First Middle Last ?		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anthony Campanaro		Address 1016 Adcock Rd.		21093			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage 131.9 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/2/1968, to 4/7/1968, that (I) (we) last saw the deceased alive on 4/7/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Lillian DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED April 8, 1968			
22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D.				22e. ADDRESS 7520 York Rd., Towson Md.,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4-10-68		23c. NAME OF CEMETERY OR CREMATORY Holy redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204				25a REC'D BY REGISTRAR DATE APR 11 1968		25b REGISTRAR'S SIGNATURE Blanche J. [Signature]	

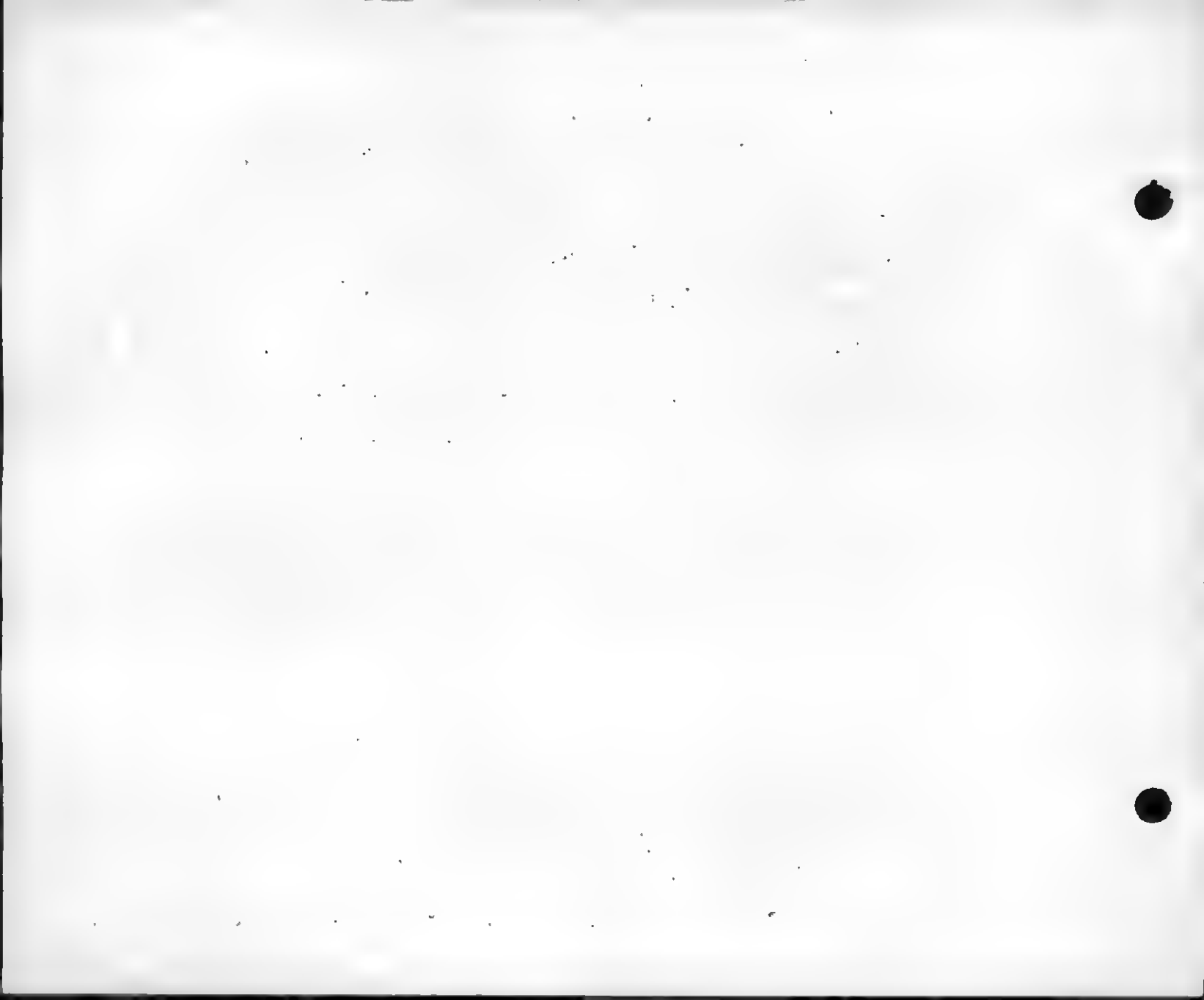


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MAY 1968											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Katherine Rebecca Sima			2a. DATE OF DEATH Month 4 Day 10 Year 68			2b. HOUR 10 AM					
3. SEX F		4. RACE C		5. DATE OF BIRTH 8-14-99			6. AGE (in years last birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) New Hampshire			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto Md.				
10. CITY OR TOWN OF DEATH Portsmouth N.H.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE 1246 Newfield Rd			13b. COUNTY Balto		13c. CITY OR TOWN County		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last Thomas Freeman Freeman			15. MOTHER'S MAIDEN NAME First Middle Last Anna Ida Freeman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 101-24-1481		17. INFORMANT Address Wm. R. Sima, Jr., son, above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tetanus of Parturition - toxemia 1420 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that if (this hospital) attended the deceased from 3/22 , 19 68 , to 4/10 , 19 68 , that if (we) last saw the deceased alive on 4/10 , 19 68 ; and that in my (our) opinion death occurred on the date and hour and from the causes stated above. if (we) (did) not view the body after death.											
22b. SIGNATURE P. L. HPSA, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/10/68				
22d. PHYSICIAN'S NAME (Type) P. L. HPSA, M.D.					22e. ADDRESS 6701 N. Charles St.						
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 4/13/68		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park			23d. LOCATION (City or Town) (County) (State) Carroll County, Md.				
24. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane					25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION



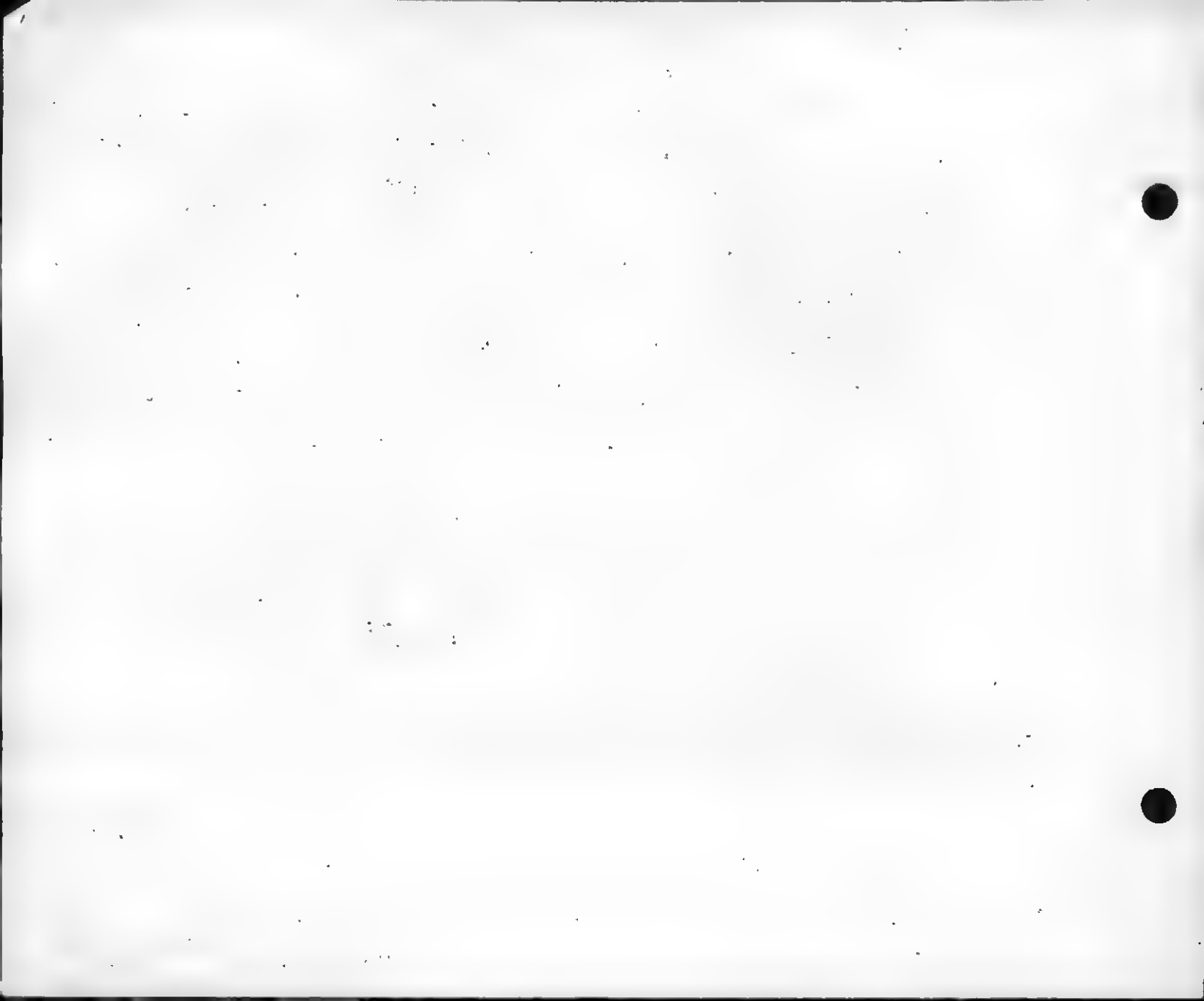
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VR A15
30M REV 1/68

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or print)				First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR Hour Minute	
HARRY LEONARD SINGLETON							April	12	'68	1:45 PM
3. SEX		4. RACE		5. DATE OF BIRTH		AGE (In years lost birthday)		6. UNDER 1 YEAR MONTHS DAY		IF UNDER 24 HRS HOURS MIN
male		WHITE		1/28/60		68 YRS		2 16		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md				
VIRGINIA		U.S.A.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Wilson		Mt. Wilson State Hosp.				JANITOR				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND		CARROLL						NEW WINDSOR		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last						
DAVE SINGLETON				ANNA SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address						
NO		172-18-0150		Records, Mt. Wilson State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA RIGHT UPPER LOBC</u> <u>16001</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>67</u> , to <u>4/12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W Newcomer</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/12/68</u>				
22d. PHYSICIAN'S NAME (Type)		William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		4/15/68		PRESBYTERIAN		NEW WINDSOR				MD
24. FUNERAL DIRECTOR <u>W. H. Hartshorn & Sons</u>		ADDRESS New Windsor		25a. REC'D BY REGISTRAR DATE <u>APR 16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



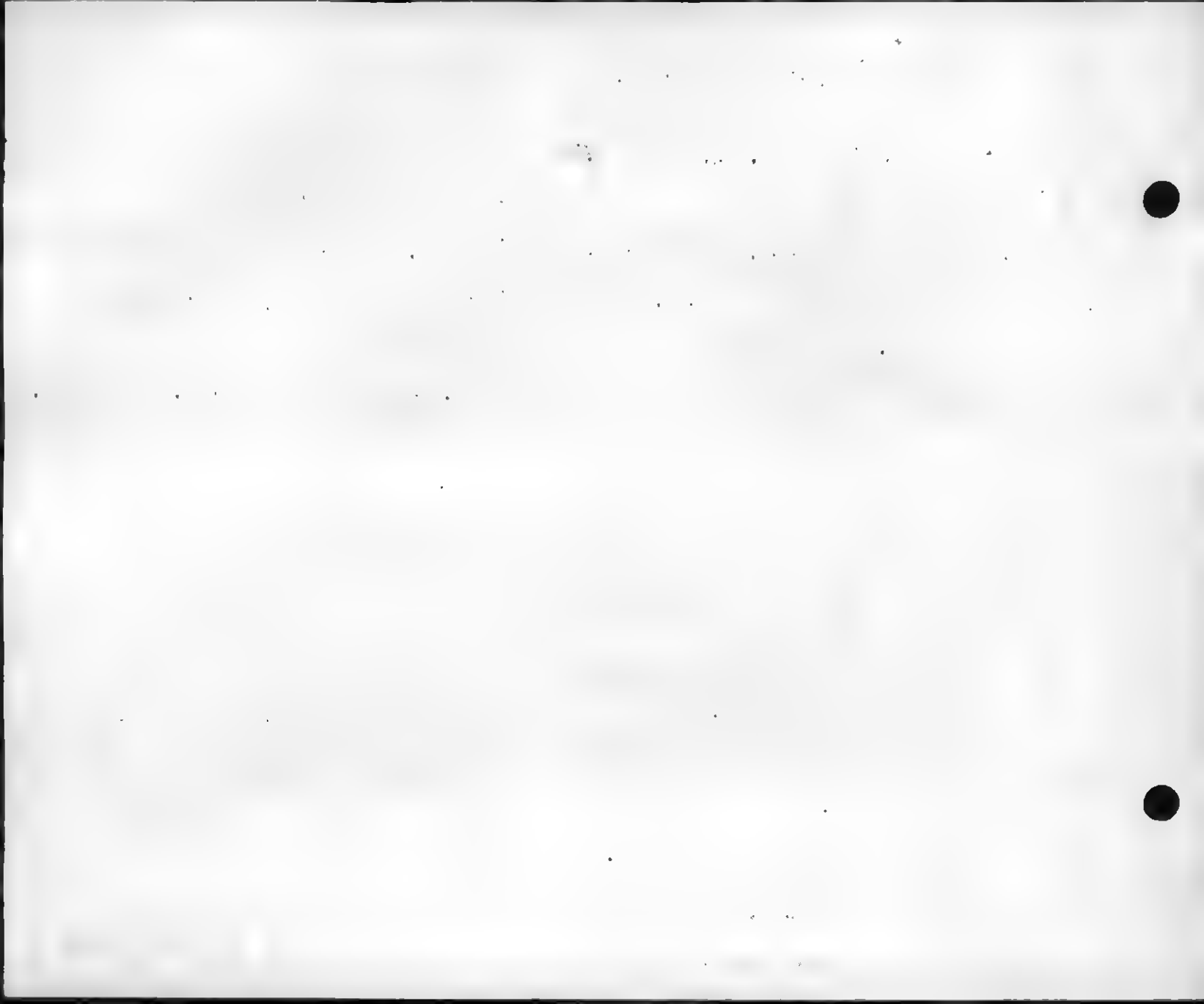
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <u>ELLA First Vaughan Simonat</u> Last <u>SOUSSAT</u>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>April</u> Day <u>13</u> Year <u>1968</u>			2b. HOUR <u>5:39</u> M		
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Nov 26, 1893</u>		6. AGE (in years and day) <u>74-75</u>		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>Tennessee</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Baltimore County</u> Md.		
10. CITY OR TOWN OF DEATH <u>Near Jacksonville, Md.</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Jarrettsville Pk & Manor Rd.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>				13b. COUNTY <u>Balto. City</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>702 Gladstone Avenue</u>	
14. FATHER'S NAME First <u>Dr. George Patterson</u> Middle <u></u> Last <u></u>				15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Vaughan</u> Last <u></u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16b. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT ADDRESS <u>Stuart G. Garrett, 517 E 84th St., New York, N.Y.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF <u>SKULL FRACTURE</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>											
19a. DATE OF OPERATION <u>4/13/68</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>AUTO ACCIDENT</u>				20. ADJUSTMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>5:40 AM 4/13/68</u>				21b. TIME OF INJURY Month, Day, Year <u>4/13/68</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>AUTO ACCIDENT</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>STREET</u>				21f. LOCATION Street or R.F.D. No <u>JARRETTSVILLE PIKE - MANOR RD</u> City or Town <u>BALTO.</u> County <u>MD</u> State <u></u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>William A. Piusbury</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>4/13/68</u>		
EXAMINER'S NAME (Type) <u>William A. Piusbury</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Cremation</u>						23b. DATE <u>Apr. 15, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>						25a. REC'D BY REGISTRAR <u>APR 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

35392

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00034

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4-21-68				2b. HOUR		
STEPHANIE (or STELLA) B.						SLONSKI								
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD				2d. HOUR	
Female	White	10/5/1920		47 YRS	MONTHS		DAYS	HOURS	MIN	April 21 1968				635 M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH								
Baltimore, Md.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
Dundalk				8324 Bletzer Road				Housewife				at home		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
8324 Bletzer Road				Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8324 Bletzer Road				
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				
Alexander				Kiwakowski						Mary Keour				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOC. SEC. NO.		17. INFORMANT		ADDRESS						
				215-03-2191		Ben P. Slonski, husband, (above)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>A-S-C-V Disease</u>														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) <u>Diabetes Mellitus</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)														
<u>Diabetes Mellitus</u>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
				HO. A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED		
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				April 23, 1968		
Melvin B. Davis, M. D.								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) 6800 Mornington Rd.		
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial				4/24/68		Dulaney Valley Mem.				Baltimore Md.				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
Schimunek Funeral Home, Inc.				3331 Brehms Lane				DATE APR 24 1968				j. charles jones		



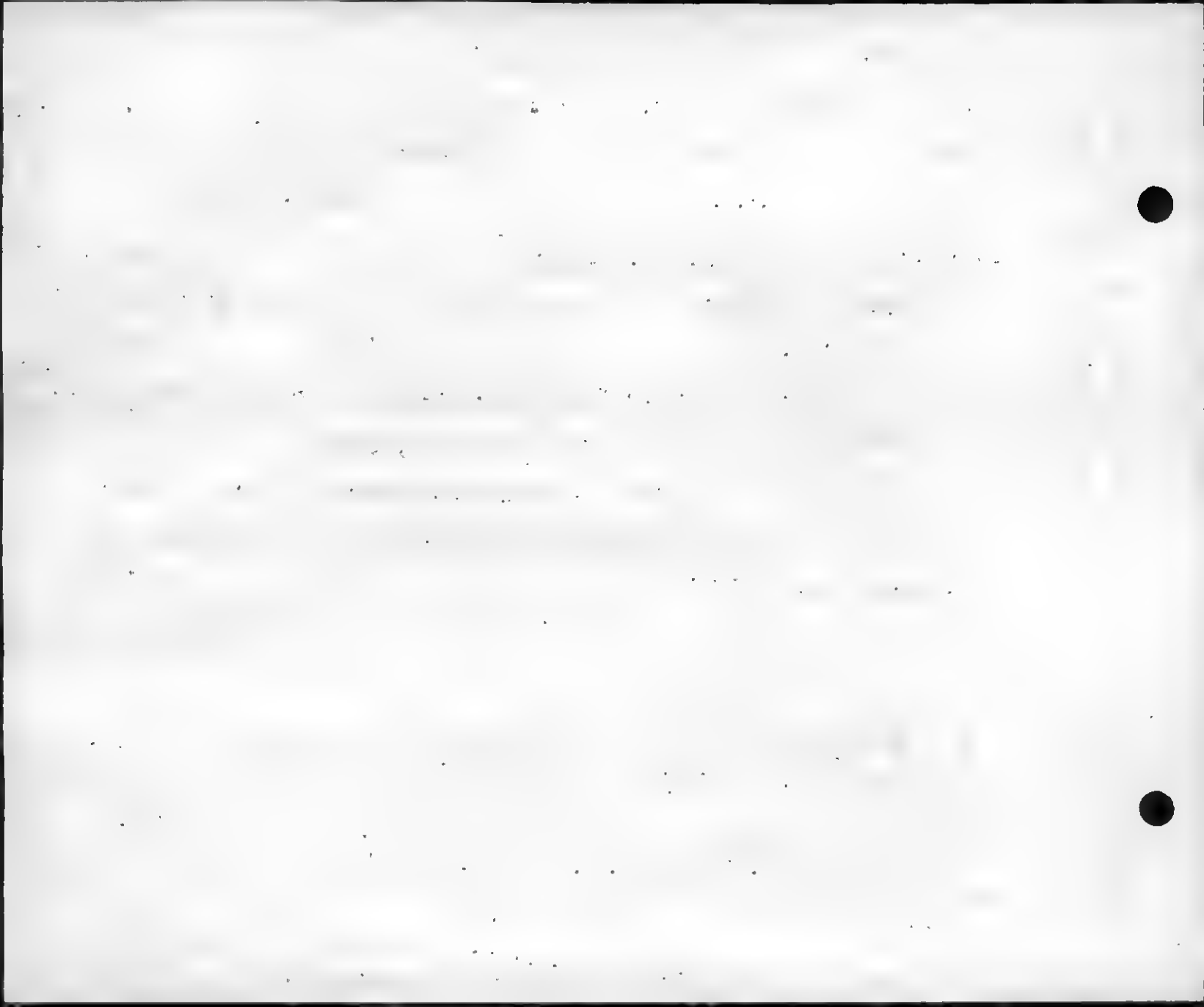
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 1-15-68
30M REV. 11/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CHARLES A. SMITH		2a. DATE OF DEATH Month 4 Day 11 Year 68 2b. HOUR 10:45 AM	
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH 11/27/22	6. AGE (In years last birthday) 45 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE COUNTY, Md
10. CITY OR TOWN OF DEATH FORT HOWARD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MECHANIC	12b. KIND OF BUSINESS OR INDUSTRY GARAGE
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND 13b. COUNTY HOWARD	13c. CITY OR TOWN ELLICOTT CITY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. INSIDE CITY - IN TSP?	13e. STREET AND NUMBER 75 NEW CUT ROAD
14. FATHER'S NAME First AMOS SMITH Middle Last	15. MOTHER'S MAIDEN NAME First VIOLA Middle Last BENTLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) YES WW I	16b. SOCIAL SECURITY NO. 218 16 00 30	17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE PONTINE, RECENT DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE, DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS GENERALIZED, OLD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OLD
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ANEURYSM BASILAR ARTERY			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from 4/9/68 , 19__, to 4/11/68 , 19__, that (1) (we) last saw the deceased alive on 4/11/68 , 19__, and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (admit) view the body after death.			
22b. SIGNATURE John D. Talbert MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/11/68
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.			22e. ADDRESS VAH FORT HOWARD, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/16/68	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. North Avenue, Baltimore, Md.		25a. BY REGISTRAR APR 15 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

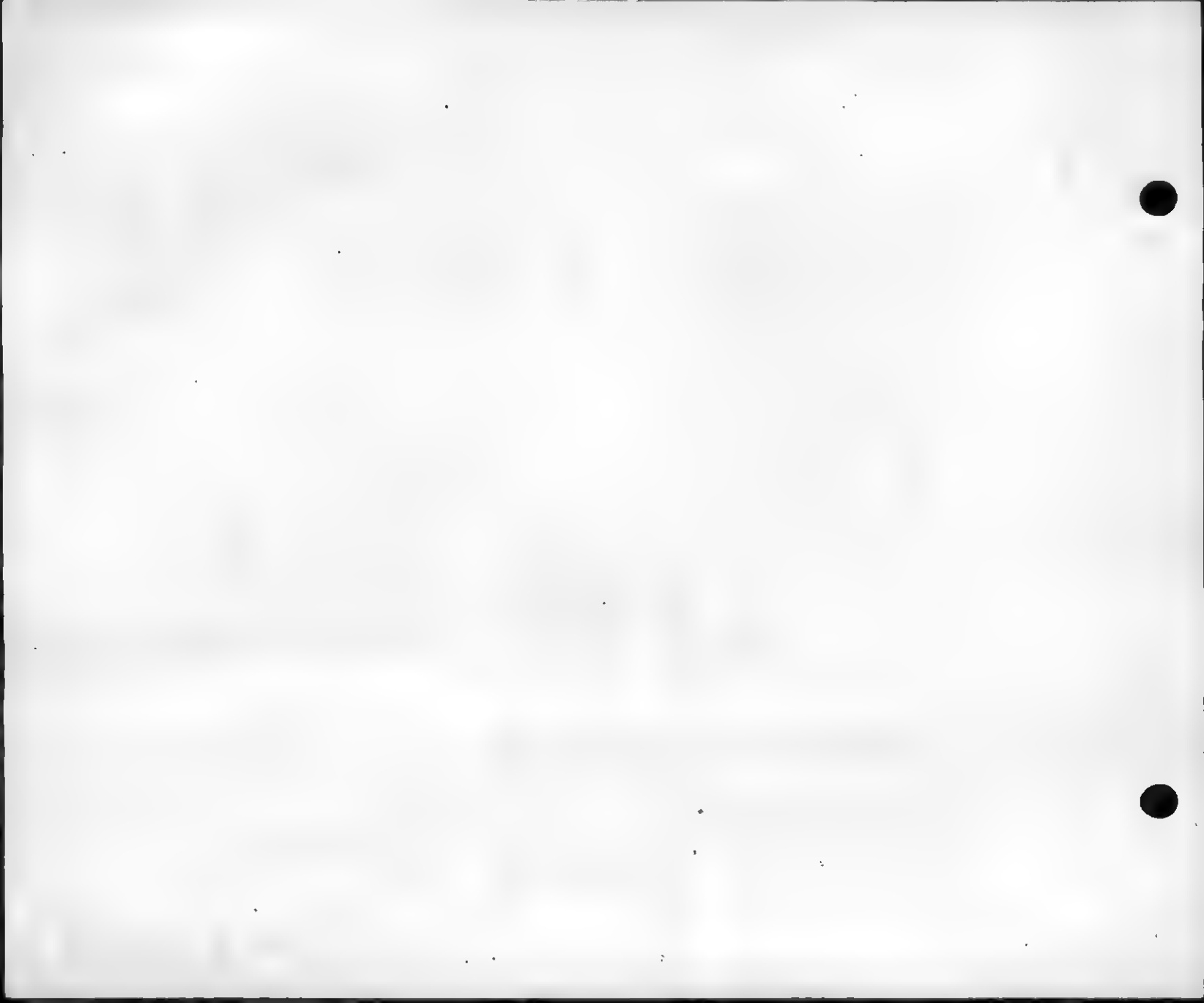


Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

1. DECEASED-NAME (Type or Print)		First		Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
HARRY M. SMITH						MAY 4-28		19	67		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
MALE	WHITE	DEC 12-1885		82 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
DUNDALK		7313 HOLMBIRD			CLERK			STORE			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		BA		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2037 FLEET ST			
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
JAMES SMITH				REBECCA EVERETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		213-48-5456		MRS BESSIE V BAUER		7313 HOLMBIRD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease DUE TO, OR AS A CONSEQUENCE OF Scurvy (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?			
				Time				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
		<19 P.M.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
M.B. Davis		M.B. DAVIS		M.D.						22b. DATE SIGNED 4/29/68	
ADDRESS(Street, city, town, or county)						DUNDALK MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		5/1/68		HOLY REPEZMER		BALTIMORE				MD	
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ULLRICH FUNERAL HOME-DUNDALK MD								MAY 01 1968		Judge	

MEDICAL CERTIFICATION



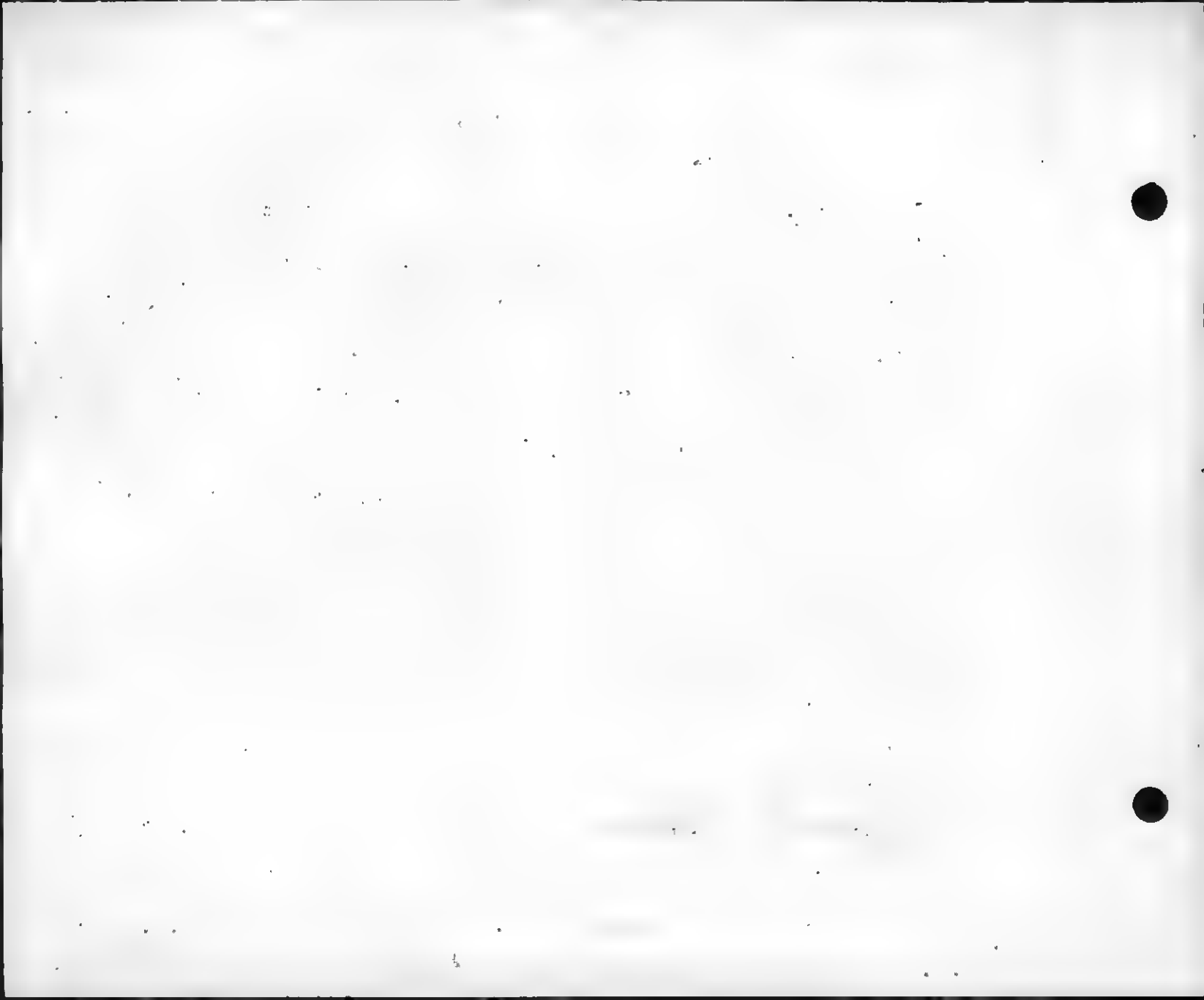
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MD 295
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
Joseph Brown Smith, Sr					Month 4 Day 27 Year 68		7:40 aM	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	NEGRO	7/4/17		50 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
ANNAPOLIS, MD.		USA				Towson Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson		Greater Balto Medical Center		BARTENDER				
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Anne Arundel		ANNAPOLIS				308 CHESTER AVENUE
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
ERNEST James SMITH		CATHERINE NMN BROWN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		216-18-3001		Beatrice P. Smith		308 Chester Ave		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Pulmonary sepsis								
DUE TO, OR AS A CONSEQUENCE OF								
(b) Carcinoma of tongue and pharynx with metastases								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/26, 19 68, to 4/27, 19 68, that (I) (we) lost saw the deceased alive on 4/27, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE						22c DATE SIGNED		
John E. Adams						4/27/68		
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS				
John E. Adams, M.D.				6701 N. Calvert Street				
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		5-1-1968		PineLawn Mem.Pk		Annapolis, A.A. Md		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
C.F. Hicks, 111 Annapolis, Md				DATE APR 30 1968		J. J. Judge		



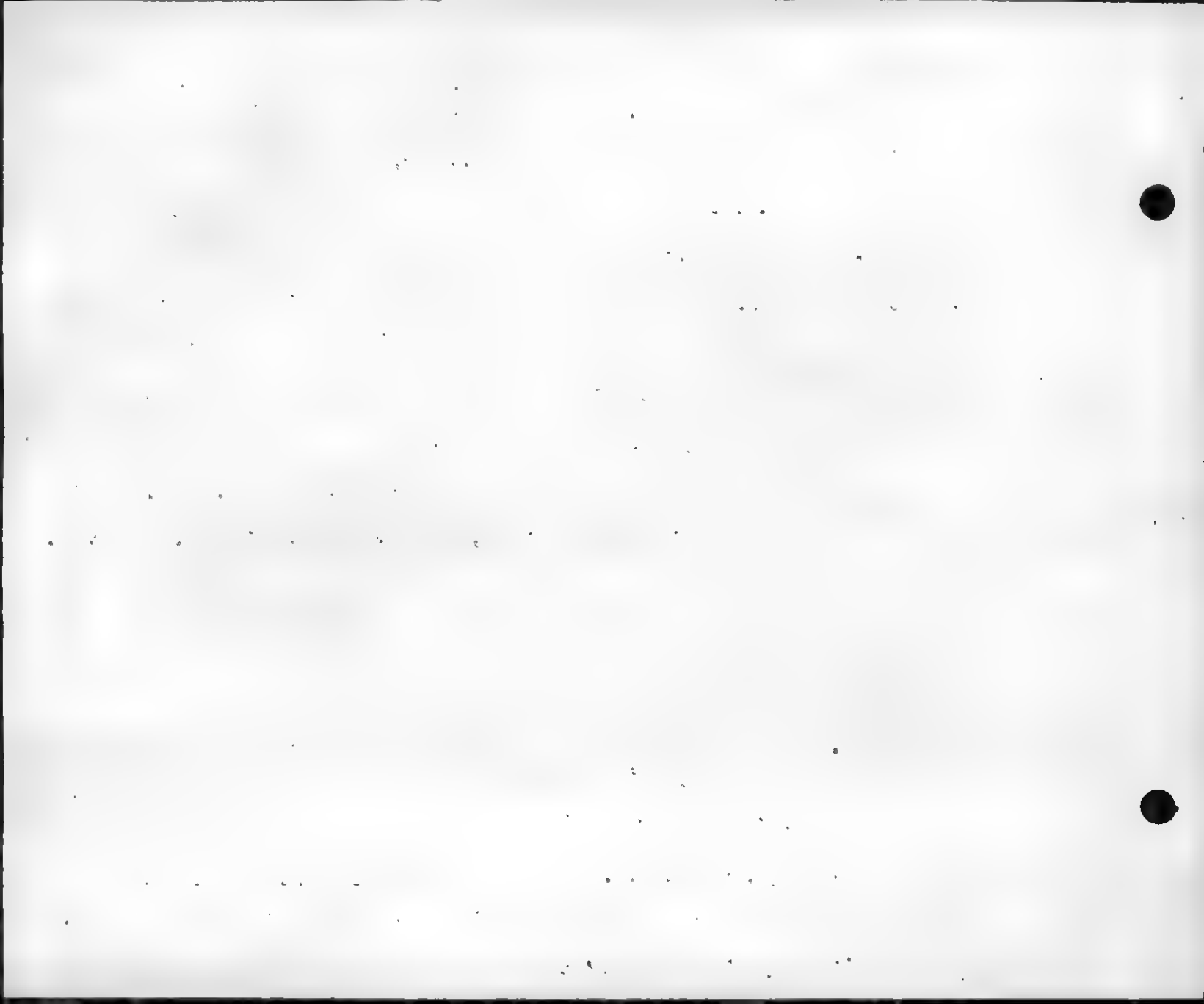
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Sommerlatt Sommerlatt		2a DATE OF DEATH Month Day Year April 30, 1968		2b HOUR 12:15 a.m.	
3 SEX Female		4 RACE white		5 DATE OF BIRTH August 28, 1886		6 AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County Md.			
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 2818 NorthWind Road			
14 FATHER'S NAME First Middle Last John Wesley Knight		15. MOTHER'S MAIDEN NAME First Middle Last Eliza Ellen Fisher							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 219-03-8843		17. INFORMANT Address Records: Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Ht. Dis. 20 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, Senile. 20 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 1, 1968, to April 30, 1968, that I (we) last saw the deceased alive on April 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) viewed (did not) view the body after death									
22b. SIGNATURE <i>Anthony J. Young</i>		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 1, 1968			
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22e. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/4/68		23c. NAME OF CEMETERY OR CREMATORY Prosperity Church Cem.		23d. LOCATION (City or Town) (County) (State) Pleasant Valley Pa.			
24. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Baltimore, Maryland		25a. REC'D BY REGISTRAR MAY 2 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

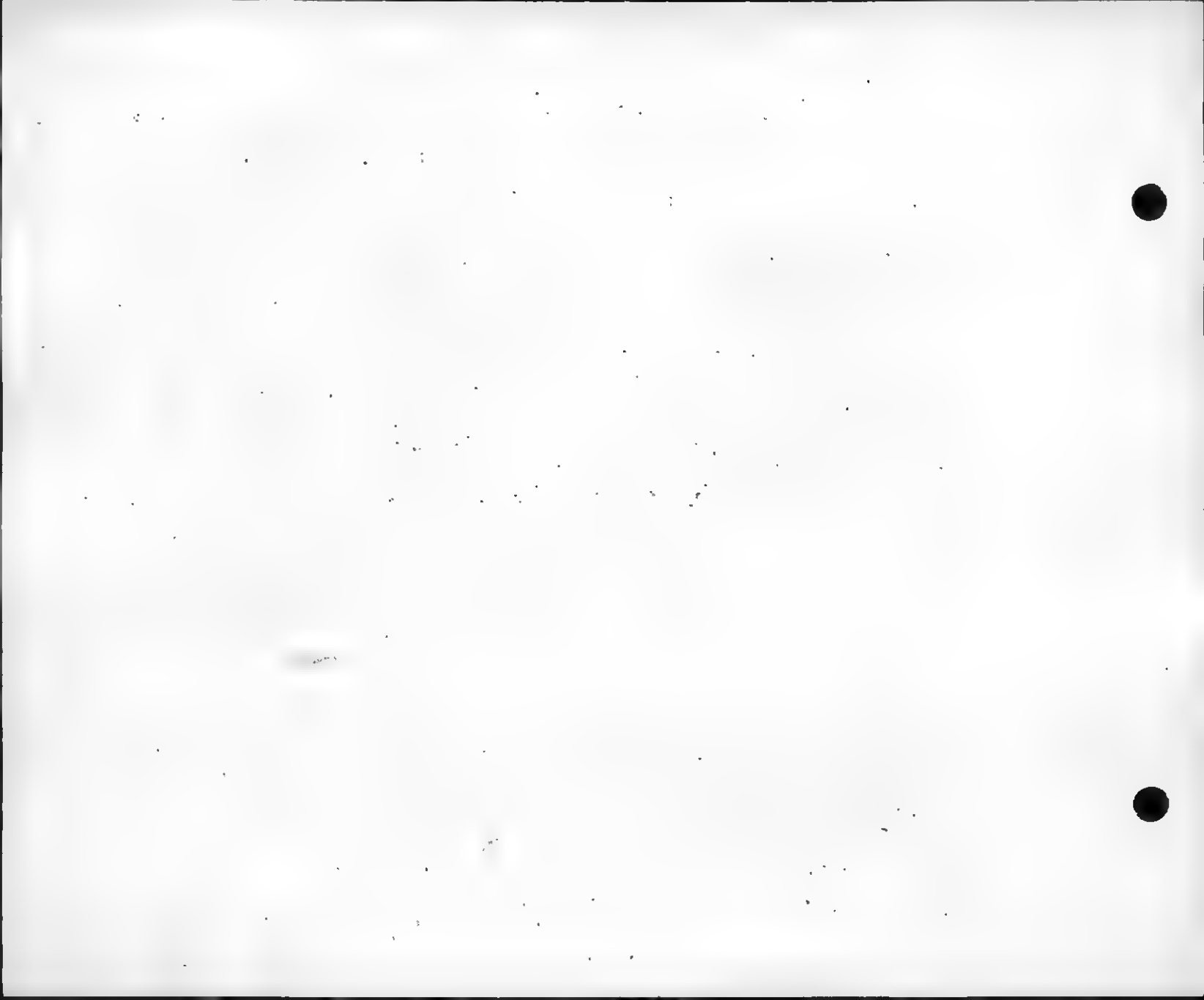


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film G399 1-15/68
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

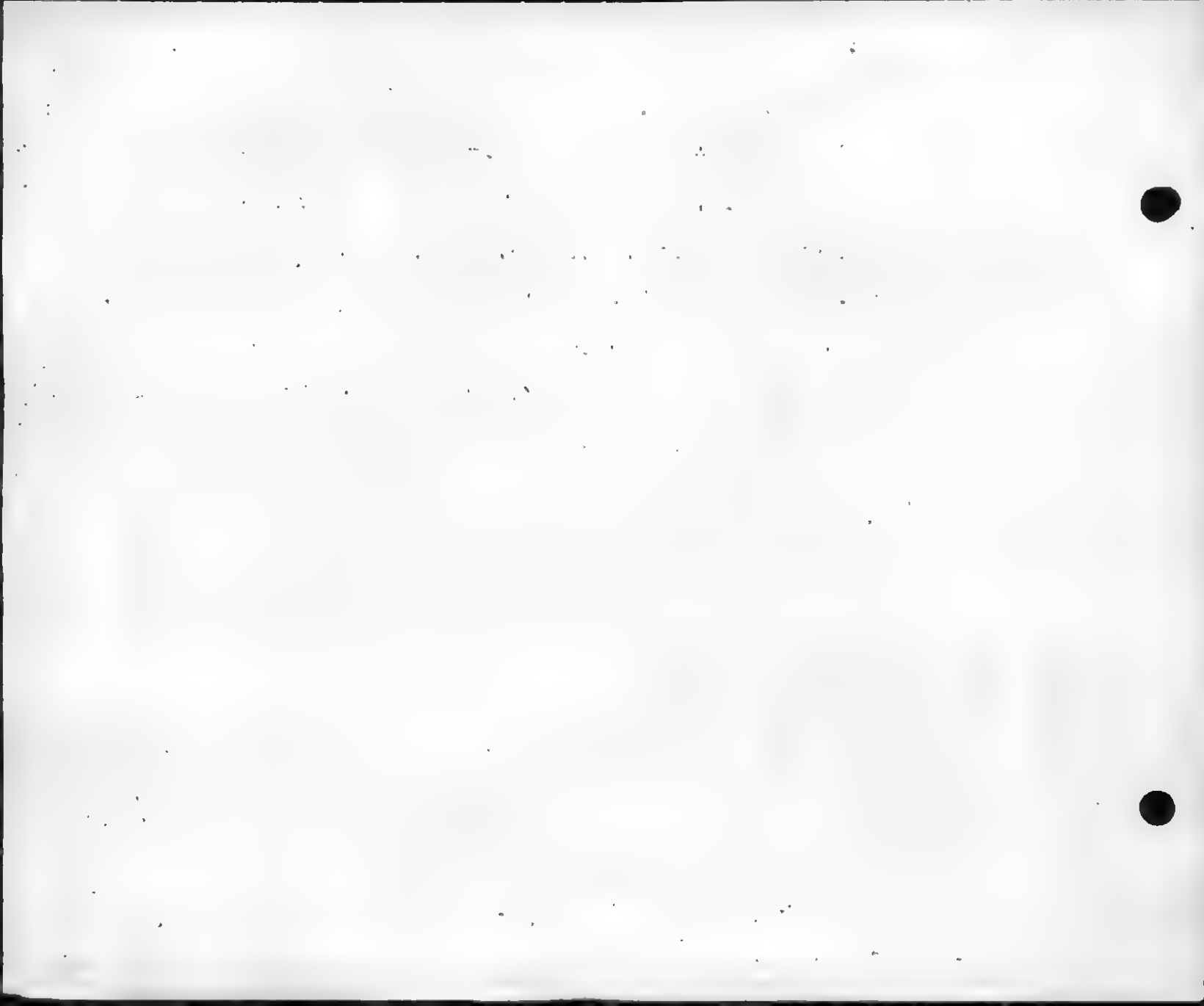
1. DECEASED NAME (Type or print) <i>Mildred Irene Stanley</i>			2a. DATE OF DEATH 4 Month 7 Day 68 Year		2b. HOUR 11:50 AM
3. SEX <i>Female</i>	4. RACE <i>Cau</i>	5. DATE OF BIRTH <i>3-26-18</i>		6. AGE (In years last birthday) <i>50</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md		
10. CITY OR TOWN OF DEATH <i>Baltimore, Md.</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>G.B.M.C.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>-</i>	13c. CITY OR TOWN <i>Baltimore</i>	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3438 Keswick Rd.</i>	
14. FATHER'S NAME First Middle Last <i>Franklin Unknown Snouffer</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>SHifley</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Patient's chart</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Perforated intra-abdominal viscus</i> 754.1 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Systemic lupus erythematosus</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12-24 hours</i> <i>6 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Hypertension</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/16</i> , 19 <i>68</i> , to <i>4/7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Derek A Bruce</i>				22c. DATE SIGNED <i>4/7/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>DEREK A. BRUCE</i>				22e. ADDRESS <i>G. B. M. C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/10-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Garden of Faith</i>	
23d. LOCATION (City or Town) (County) (State) <i>Baltimore City Md</i>		24. FUNERAL DIRECTOR <i>Frank H Seitz 814 W 36th St</i>			
25a. REC'D BY REGISTRAR DATE <i>APR 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Charles		First L.		Middle Stauffer		Last SR		2a. DATE OF DEATH Month 04 Day 06 Year 68		2b. HOUR 4:00	
3. SEX Male		4. RACE white		5. DATE OF BIRTH 9-30-03				6. AGE (in years) as of (day) 04 YRS		7. IF UNDER 1 YEAR MONTHS 04 DAYS 06	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.					
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired				12b. KIND OF BUSINESS OR INDUSTRY Sealtest Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3526 Rolling Rd.			
14. FATHER'S NAME First Artie Middle Stauffer Last Wilt		15. MOTHER'S MAIDEN NAME First Ella Middle Wilt Last Wilt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Wm. Charles L. Stauffer SR Address 21397 3526 Rolling Rd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 415.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) T x U.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/6 , 19 68 , to 4/6 , 19 68 , that (I) (we) last saw the deceased alive on 4/6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur A. Serpick		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/6/68					
22d. PHYSICIAN'S NAME (Type) Arthur A. Serpick		22e. ADDRESS 5601 Old Court Rd									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/9/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn, Md					
24. FUNERAL DIRECTOR Henry Byers - 8725 Liberty Road		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

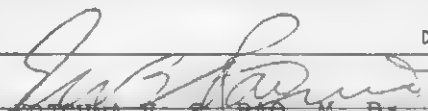



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

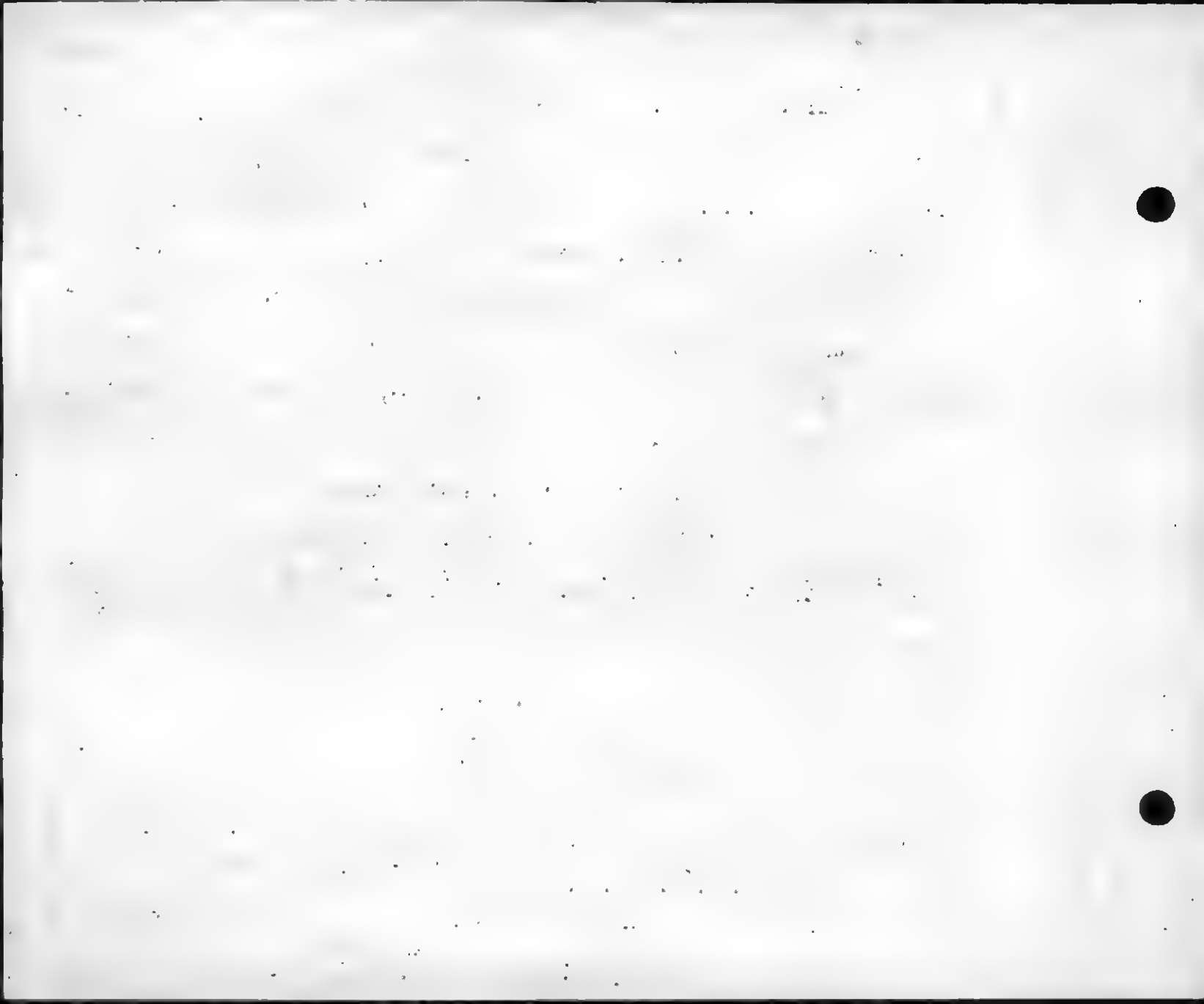
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First WILLARD	Middle E.	Last STEWART	2a. DATE OF DEATH Month 4 Day 18 Year 68		2b. HOUR 1:30 A.M.
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 9/26/90		6. AGE (In years last birthday) 77 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY, Md.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First John		Middle Steward		Last ANNIE		15. MOTHER'S MAIDEN NAME First MASON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO 215 10 02 74		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 4/18/68 DUE TO, OR AS A CONSEQUENCE OF (b) THROMBOSIS, RIGHT VETERAL ARTERY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH RECENT							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ARTERIOSCLEROSIS, MARKED GENERALIZED AND CEREBRAL, BENIGN PROSTATIC HYPERTROPHY, CHRONIC CYSTITIS, BURNS (THERMAL) POSTERIOR THIGHS, LEGS, PERINEUM AND PENIS,							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (b) (this hospital) attended the deceased from 2/5/68 , 19 68 , to 4/18/68 , 19 68 , that (b) (we) last saw the deceased alive on 4/18/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (not) view the body after death.							
22b. SIGNATURE 						22c. DATE SIGNED 4/18/68	
22d. PHYSICIAN'S NAME (Type) PRISHNA V. S. RAO, M.D.						22e. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/23/68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ROLAND BROWN FUNERAL				25a. REC'D BY REGISTRAR APR 23 1968		25b. REGISTRAR'S SIGNATURE 	

ADDRESS
ROLAND BROWN FUNERAL
123 W. Montgomery St. Baltimore, Md.

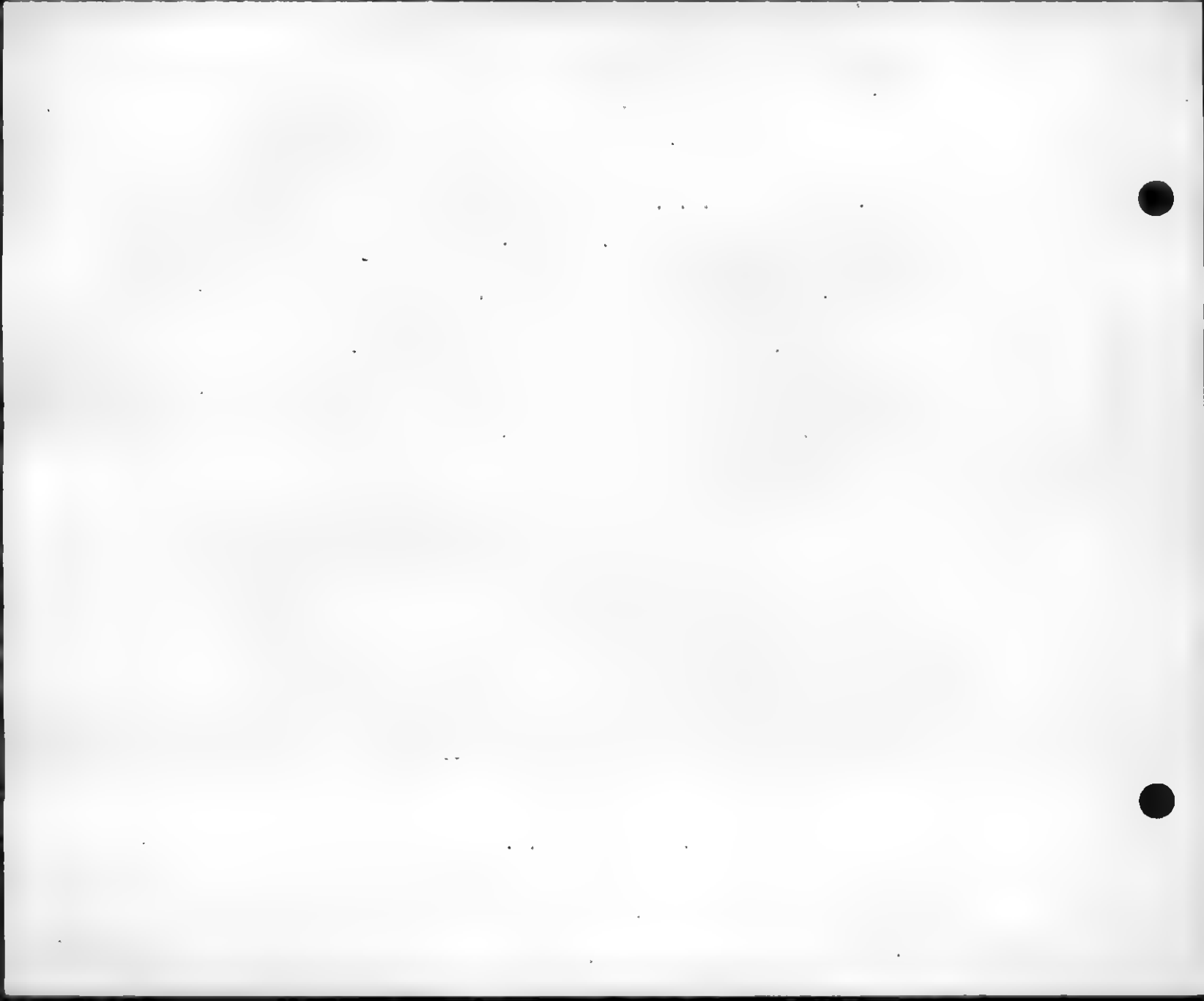


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) WILLIAM			First Middle Last F. SWIST			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year April 5, 1968		2b. HOUR 9:50 AM		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 10-9-1915	6 AGE (In years last birthday) 52 YRS	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month April Day 5 Year 1968		
7a BIRTHPLACE (State or foreign country) Massachusetts		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		2d. HOUR 9:50 AM		
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holiday Inn			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tech. Engineer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Mass.			13b COUNTY Fall River		13c. CITY OR TOWN Fall River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 85 Chace Street	
14 FATHER'S NAME First Middle Last William J. Swist			15 MOTHER'S MAIDEN NAME First Middle Last Mary A. Cartin			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				
16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS Fall River, Donnelly Funeral Home, 1173 S. Main St. Mass.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 221 Acute Ethylism										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		
						County		State		
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Ronald N. Kornblum			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4-5-68				
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
			ADDRESS (Street, city, town, or county)							
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b DATE 4-9-1968			23c NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery			23d. LOCATION (City or Town) (County) (State) Fall River, Massachusetts	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			ADDRESS			25a REC'D BY REGISTRAR APR 10 1968		25b REGISTRAR'S SIGNATURE [Signature]		



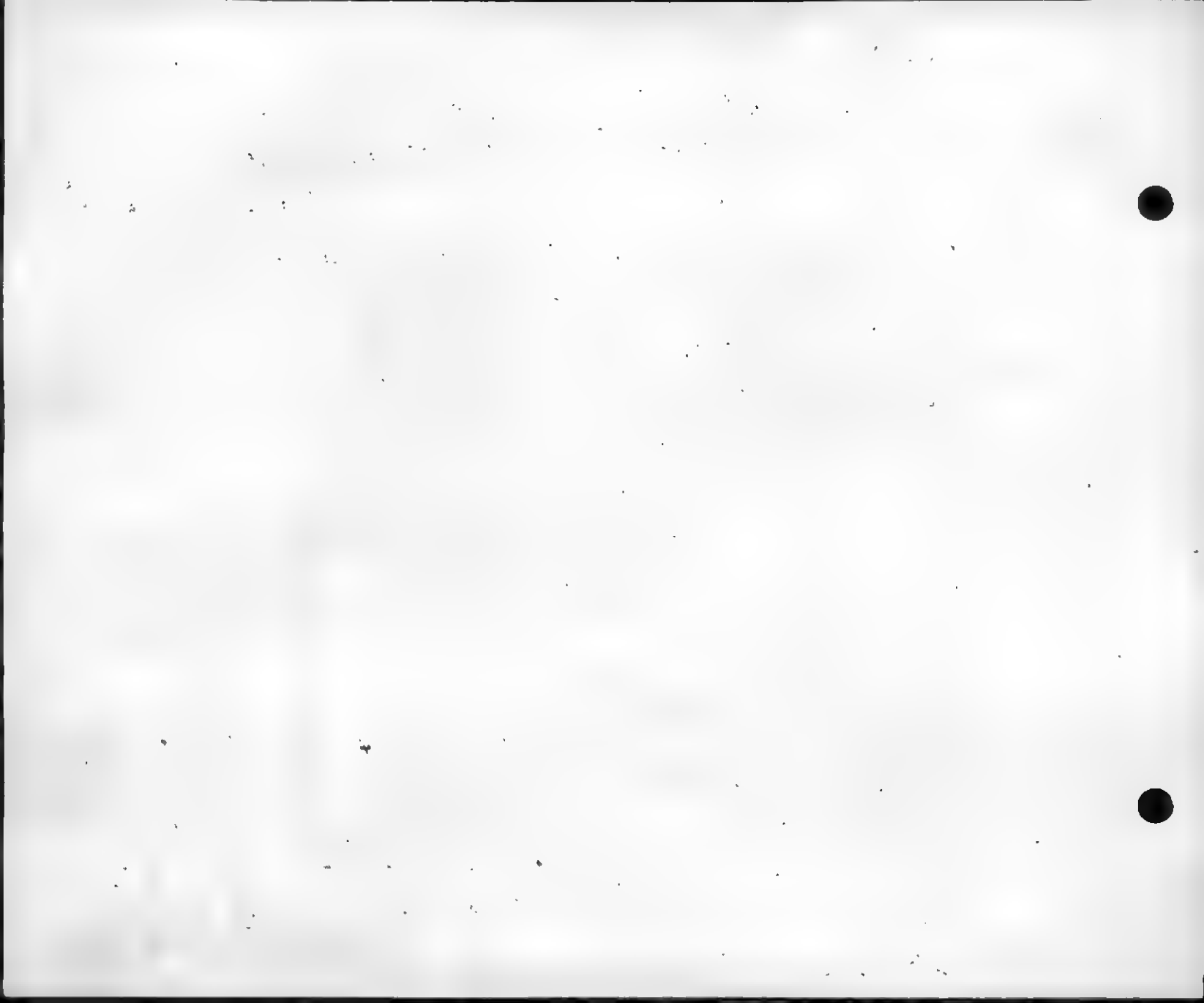
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

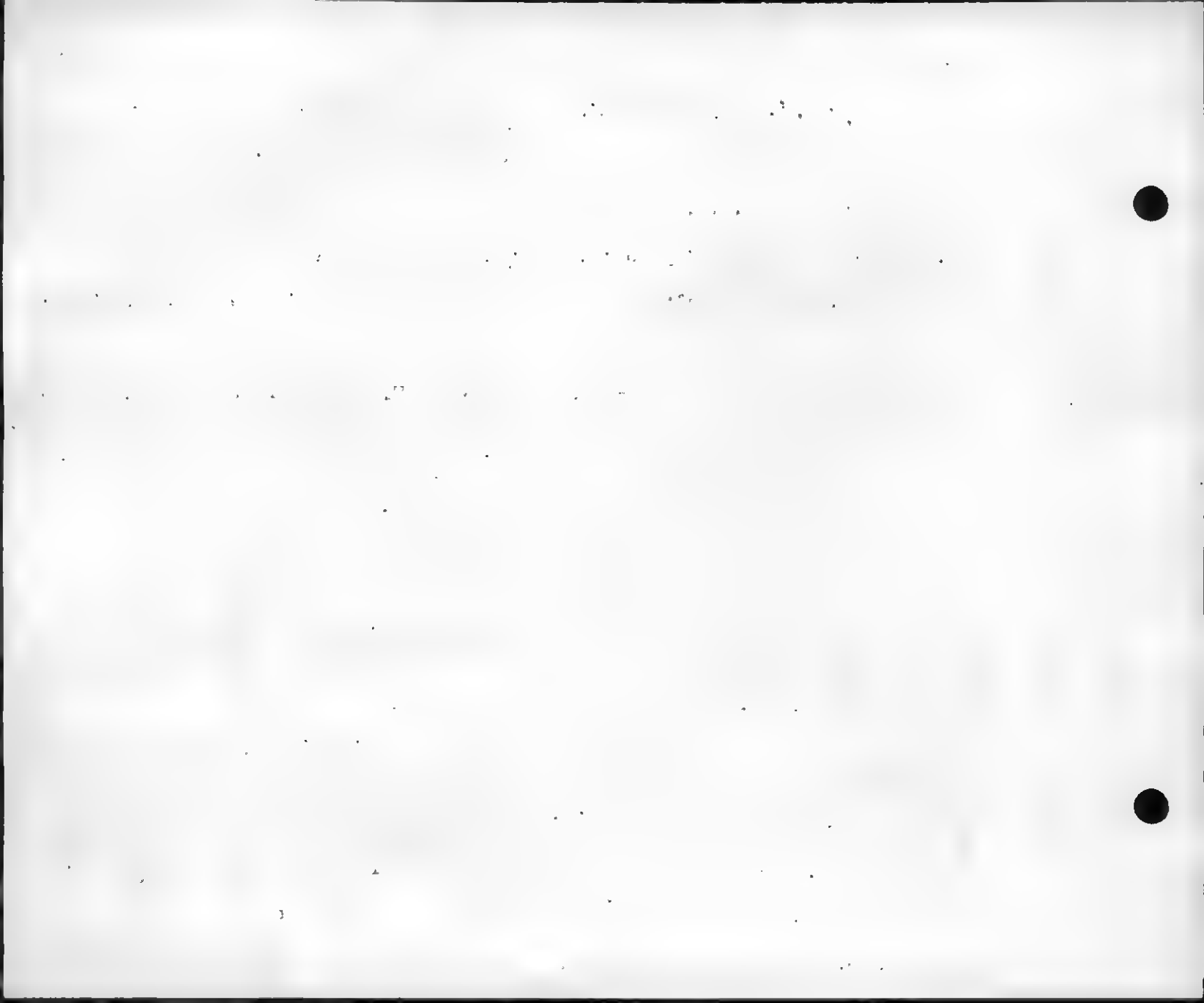
1. DECEASED-NAME (Type or print) Stanley Sykes			2a. DATE OF DEATH Month 4 Day 17 Year 1968			2b. HOUR 6:25 p. M.							
3 SEX Male		4. RACE negro		5. DATE OF BIRTH 12-25-1887		6 AGE (In years last birthday) 80 YRS.		7 UNDER YEAR MONTHS 8 DAYS 17		8 UNDER 4 HRS. HOURS 6 MIN 25			
7a BIRTHPLACE (State or foreign country) Virginia, US		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md							
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Spring Grove State Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Porter			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased admission) STATE Md.			13b COUNTY Baltimore			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 905 W. Saratoga St. Baltimore	
14 FATHER'S NAME First John Middle Wesley Last Sykes			15 MOTHER'S MAIDEN NAME First Mary Middle Last 										
16a WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) yes (If yes give war or dates of service) Army 1917-1919			16b. SOCIAL SECURITY NO. unknown			17. INFORMANT Hospital Record.			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Left Hemiplegia due to Cerebral Thrombosis													
19a. DATE OF OPERATION 20			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from February 11, 1964 , to April 17, 1968 , that (I) (we) last saw the deceased alive on April 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Raul L. Machado 11669			DEGREE 11669			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/17/1968				
22d. PHYSICIAN'S NAME (Type) Raul L. Machado M.D.			22e. ADDRESS Spring Grove State Hospital										
23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial			23b. DATE 4-22-68			23c. NAME OF CEMETERY OR CREMATORY Baltimore Cat			23d. LOCATION (City or Town) (County) (State) Baltimore Md				
24. FUNERAL DIRECTOR Elroy Wilson			ADDRESS 1135 Brantly Ave. Baltimore			25a. REGD BY REGISTRAR DATE APR 19 1968			25b. REGISTRAR'S SIGNATURE James Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		
MADELINE E. TATE									April 25, 1968		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 FINDER YEAR		
Female		White		July 20, 1901			66 YRS		MONTHS DAYS HOURS M.N.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Catonsville			Shady Nook Nursing Home			Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS. OF CITY, COUNTY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Baltimore		Arbutus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1320 Stevens Ave. 21227		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
William Funk				Mary Roeder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT		Address				
Yes, no, or unknown			215-01-3888		Mrs. Sarah Till, 2023 Annapolis Rd.		21230				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) <u>Carcinoma of Uterus</u>										9 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-19-68</u> to <u>April 25, 1968</u> , that (I) <u>was</u> last saw the deceased alive on <u>4-19-68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.											
22b. SIGNATURE <u>Earl Pass M.D.</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4-25-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Earl Pass</u>						22e. ADDRESS <u>4001 Wilkens Ave., Balto., Md.</u>					
23a BURIAL, CREMATION, REINTERMENT		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
BURIAL		4-29-1968		Loudon Park Cemetery			Baltimore, Maryland				
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Howard H. Hubbard, 4107 Wilkens Ave.						21229			DATE <u>APR 29 1968</u>		
						25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

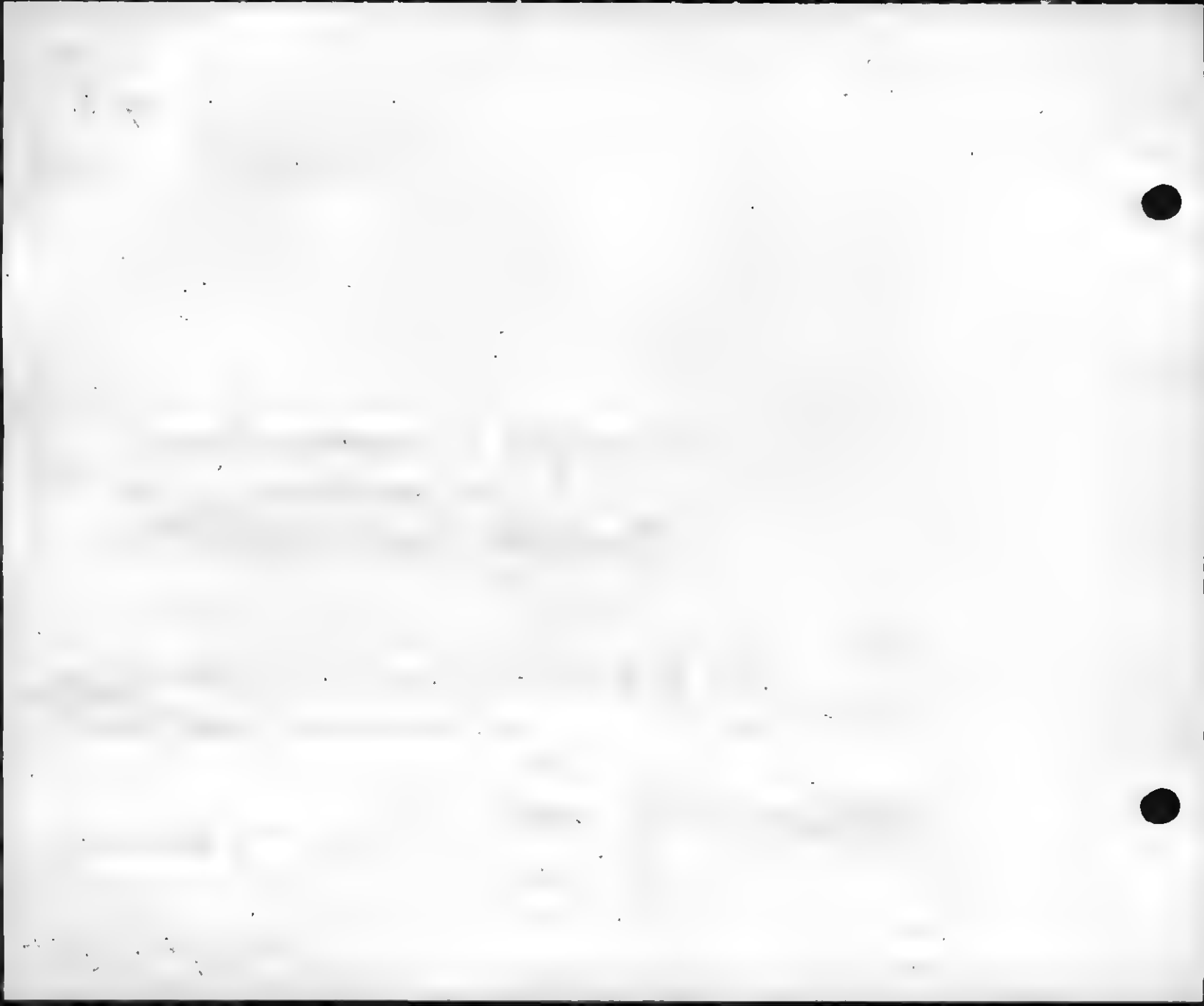


FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14 1
MAY 2008
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) H. Jackson			2a. DATE KNOWN OF DEATH April 29 1968			2b. HOUR 8:45 AM		
3 SEX M	4 RACE W	5. DATE OF BIRTH 4-12-1950	6 AGE 18 YRS	IF LARGER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD April 29 1968
7a. BIRTHPLACE (State or foreign country) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		
1d. CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY High School
13a. U.S.A. RESIDENCE (Where deceased lived, if institution on residence before admission) STATE Md.			13b. COUNTY Baltimore - Freeland		13c. CITY OR TOWN Freeland		13d. STREET AND NUMBER Eagle Mill Rd.	
14. FATHER'S NAME H. Jackson			15. MOTHER'S MAIDEN NAME Sarah Kathryn Provost					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) No			16b. SOCIAL SECURITY NO. 213-50-4767			17. INFORMANT H.S. Taughinbaugh, Freeland, Md		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple Crushing Injuries DUE TO, OR AS A CONSEQUENCE OF (b) of Chest and Head. DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Fractures of Left Femur PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 9:30 AM April 28 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Probably in Head-on Crash with no other			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION (Street or RFD No., City or Town, County) Wacker'sville Rd. North Parkton			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles F. O'Donnell			M.D.			22b. DATE SIGNED 4/29/68		
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.			ADDRESS (Street, city, town or county)					
23a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial			23b. DATE 5-1-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Lion Cemetery		23d. LOCATION (City or Town, County, State) Freeland, Baltimore, Md.	
24. FUNERAL DIRECTOR Jacob Hartenstein			ADDRESS New Freedom, Pa.			25a. REC'D BY REG. STRA. MAY 2 1968		25b. REGISTRAR'S SIGNATURE Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portion of page 3 and send it to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-15 (4-76)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Baby Girl Mary Christine Tayag			2a. DATE OF DEATH 4 Month 27 Day 68 Year		2b. HOUR 6:04 a.m.
3. SEX Female	4. RACE Cau	5. DATE OF BIRTH 4/26/68		6. AGE (In years last birthday) 0 YRS	IF UNDER 1 YEAR MONTHS 1 DAYS IF UNDER 24 HRS HOURS 1 MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Balto	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 8216 Thornton Rd.	
14. FATHER'S NAME First Middle Last Balbino Z. Tayag		15. MOTHER'S MAIDEN NAME First Middle Last Diadema Simon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. None	17. INFORMANT Address Dr. Balbino Z. Tayag 8216 Thornton Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1769 DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxia DUE TO, OR AS A CONSEQUENCE OF (c) Maternal shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No. City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 26, 1968 , to April 27, 1968 , that (I) (we) lost saw the deceased alive on April 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John E. Adams</i>				22c. DATE SIGNED 4/27/68	
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.				22e. ADDRESS 6701 N. Charles Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	
23d. LOCATION (City or Town) (County) (State) Cockeysville, Md. Balto.		24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204			
25a. REC'D BY REGISTRAR MAY 3 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Mevin</i> First <i>H.</i> Middle <i>Teufel</i> Last			2a DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1968</i>			2b. HOUR <i>1:20</i> P.M.					
3. SEX <i>M</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>2/13/05</i>		6. AGE (In years lost birthday) <i>63</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7a BIRTHPLACE (State or foreign country) <i>md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md					
10 CITY OR TOWN OF DEATH <i>Catoxville</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Hm</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Catoxville</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>5713 Edmondson Ave.</i>		
14 FATHER'S NAME First <i>John</i> Middle <i>Teufel</i> Last			15 MOTHER'S MAIDEN NAME First <i>Pauline</i> Middle <i>Mitchell</i> Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>705-05-2540</i>		17. INFORMANT Address <i>21228 Mrs. Marie M. Teufel, 5713 Edmondson Ave.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) <i>Myocardial Degeneration</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Lung</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cirrhosis of Liver</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD. No. <i></i>		City or Town <i></i>		County <i></i>		State <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1966</i> to <i>28 April 1968</i> , that (I) (we) last saw the deceased alive on <i>28 April 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William J. Bryson</i>				DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>30 April 68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Dr. William W. Bryson</i>				22e. ADDRESS <i>4605 Edmondson Ave., Balto., Md.</i>							
23a. BURIAL, CREMATION, RESURRECTION (Specify)		23b. DATE <i>5-1-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Maryland</i>					
24 FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>MAY 01 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by an authorized director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

4 1
00206
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Bertha		First Middle Last		2a. DATE OF DEATH Month April Day 23 Year 1968		2b. HOUR 7:55 p. 55 M	
3. SEX female		4 RACE white		5 DATE OF BIRTH May 24, 1877		6 AGE (In years last birthday) 90 YRS	
7a BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Unknown to records		15. MOTHER'S MAIDEN NAME First Middle Last Unknown to records		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			
16b SOCIAL SECURITY NO. 212-07-5200		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right carotid artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 1121 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 17, 1967 to April 23, 1968 , that (I) (we) last saw the deceased alive on April 23, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b SIGNATURE Dr. Diomidis L. Pirovolidis		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 4-23-68	
22d PHYSICIAN'S NAME (Type) Diomidis Pirovolidis, M.D.		22e ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/29/68		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PK. Cem		23d LOCATION (City or Town) (County) (State) BALTO. Md.	
24 FUNERAL DIRECTOR E. S. MacNabb		ADDRESS 301 Frederick Rd Catonsville Md.		25a REC'D BY REGISTRAR APR 30 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. This may be retained for your files.

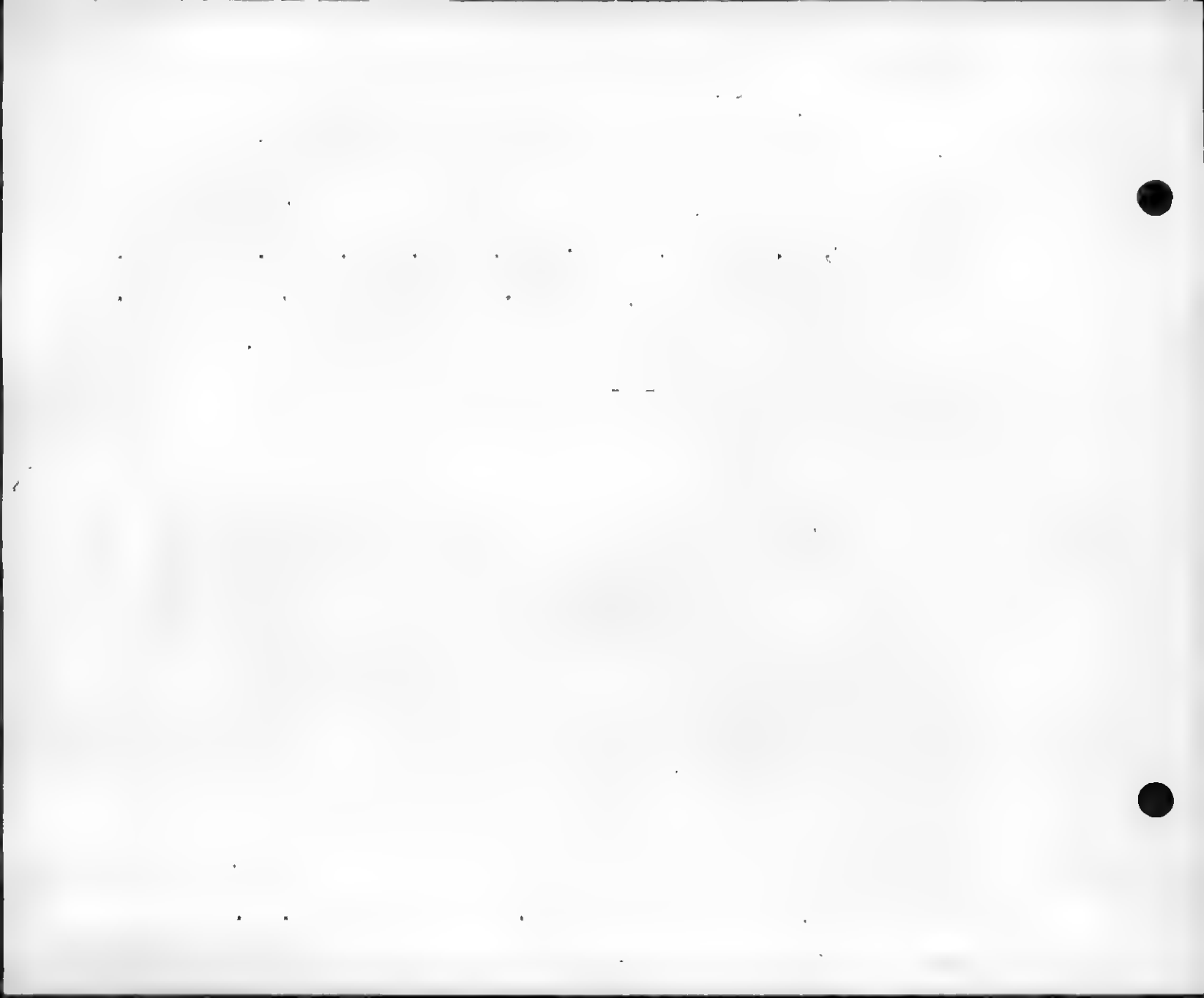
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b HOUR			
F. Lee Thomas						4-29 1968			2 34 M						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR				
M.	W.	4/27/1898	70 YRS					Month 4 Day 29 Year 1968			4 34 M				
7a BIRTHPLACE (State or foreign country)			7b CT ZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH						
Md.			U.S.A.						Baltimore Md						
10 CTY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Middle River, Md.			3 A. Oak Grove Dr. Balto.			Ret. Balto. Transit Co.									
3a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER			
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3 A. Oak Grove Dr.			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
William Thomas			Emma V. Stayler												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
no			213-10-2790A			Christine Thomas			Same						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>H-S-C-V Disease</u> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 422															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No			City or Town			County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER			22b DATE SIGNED			
EXAMINER'S NAME (Type)			Molvin B Davis MD			6800 MORNINGTON RD, 21222			4/29/68						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County) (State)			
Burial			5/2/68			Woodlawn Cem.			Balto. Md.						
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG STRAR			25b REGISTRAR'S SIGNATURE						
Leonard J Ruck Inc, Baltimore, Maryland						DATE APR 29 1968			Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

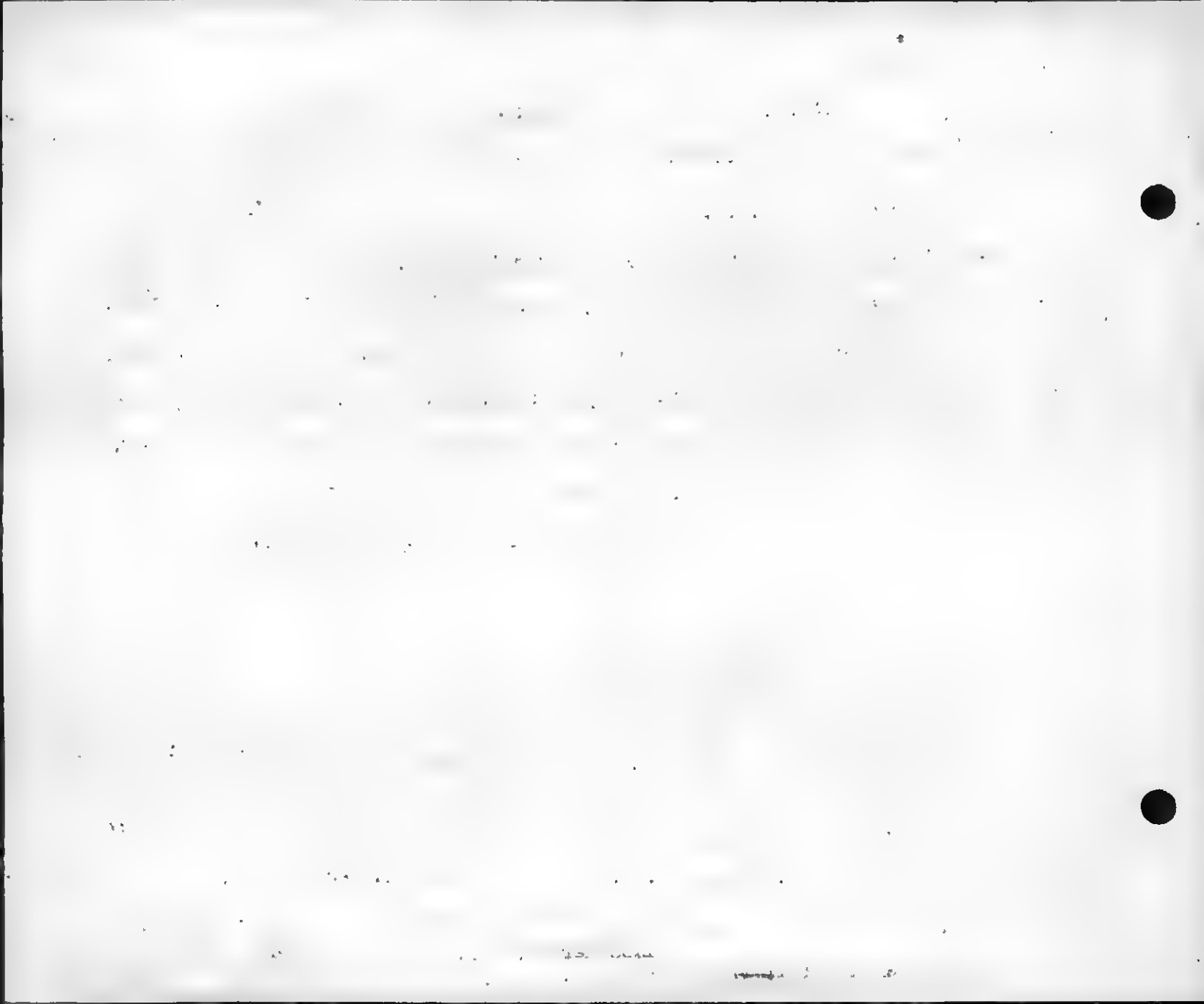
VR A15 (4)
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05410

1. DECEASED NAME (Type or print) ERNEST THOMPSON		First Middle Last		2a. DATE OF DEATH Month Day Year APRIL 20 1968		2b. HOUR 5:00 PM	
3. SEX Male		4. RACE Colored		5. DATE OF BIRTH 11/26/12		6. AGE (In years last birthday) 55	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.	
10. CITY OR TOWN OF DEATH Fort Howard		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration Hosp. Burner		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steel		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. STREET AND NUMBER 656 Bartlett Avenue	
14. FATHER'S NAME First Middle Last Samuel Thompson		15. MOTHER'S MAIDEN NAME First Middle Last Agnes Henson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. WW II 218-03-5170		17. INFORMANT Clin. Records, VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHIOPNEUMONIA CONFLUENT BILATERAL 144 X DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY ABSCESS, RIGHT UPPER LOBE DUE TO, OR AS A CONSEQUENCE OF (c) POST OPERATIVE CARCINOMA OF FLOOR OF MOUTH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS MONTHS YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 15, 1967 , to April 20, 1968 , that (I) (we) last saw the deceased alive on April 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (aid) (did not) view the body after death.							
22b. SIGNATURE Mario J. Quiros, M.D.		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4 21 68	
22d. PHYSICIAN'S NAME (Type) MARIO J. QUIROS, M.D.		22e. ADDRESS VAH, FORT HOWARD, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR MARSHALL JONES FUNERAL HOME		ADDRESS 1735 Harford Ave.		25a. REC'D BY REGISTRAR APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

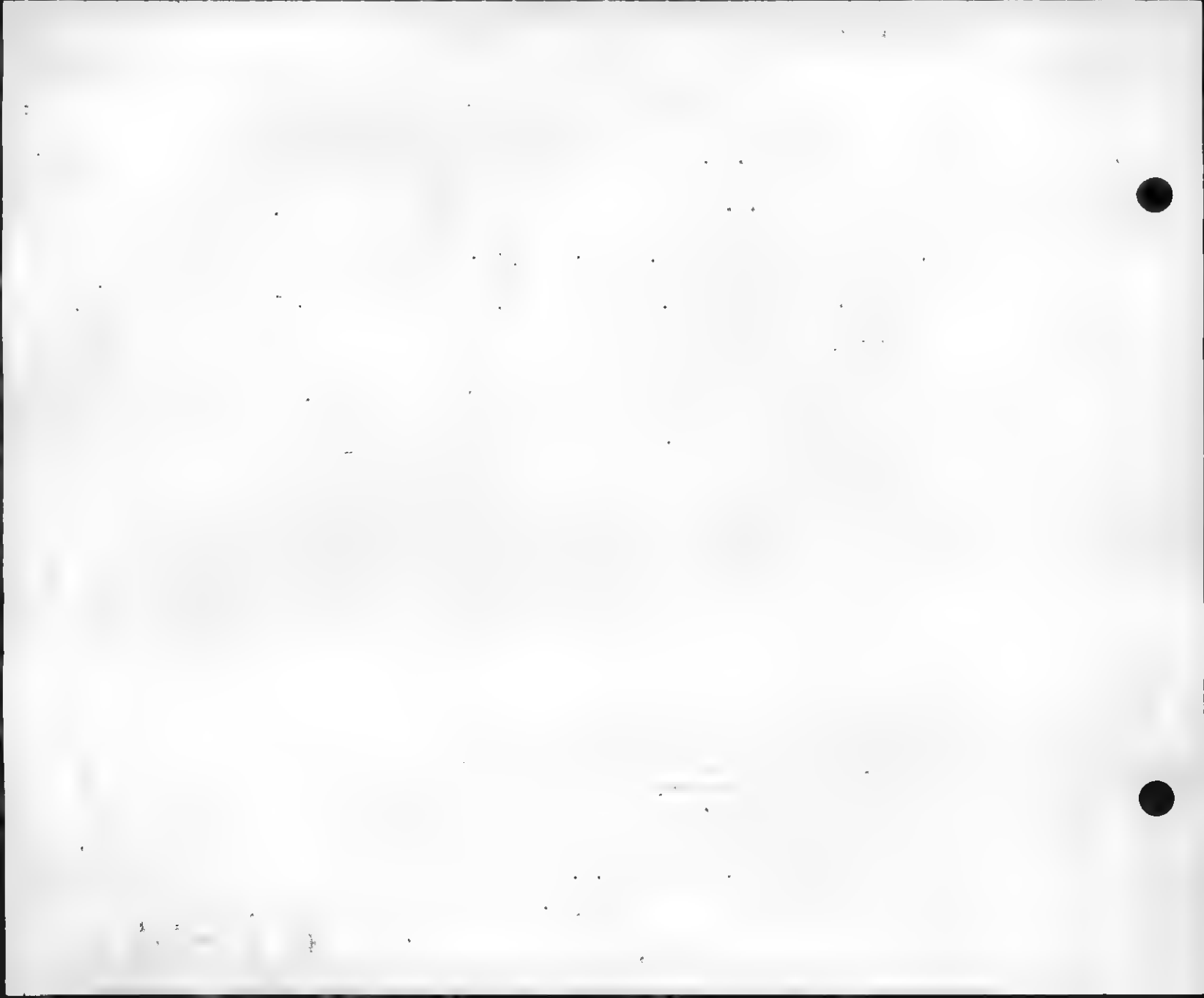


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 1 144
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF EST- DEATH MATED			2b. HOUR		
MARY			KIMBERLY Glenn			TIEPERMAN			Month Day Year 1968 11:20		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Jan. 29, 1968	YRS 4	MONTHS	DAYS	HOURS	MIN	Month Day Year 1968 11:20			
7a. BIR PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.					MD
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Balto.			St. Joseph Hospital								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Balto.			Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			Apt. C		
First Middle Last			First Middle Last			8417 Loch Raven Blvd.					
Richard Glenn Tieperman			Mary Beverly Rhodes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			None			Mr Richard G Tieperman			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Interstitial pneumonia (SDII)</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
5-25X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>											
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward F. Wilson</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			April 20, 1968		
Edward F. Wilson, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			4/22/68			Moreland Memorial Pk			Baltimore, Maryland		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Leonard J Ruck Inc Baltimore, Maryland									APR 22 1968		
									25b. REGISTRAR'S SIGNATURE		
									Charles Judge		

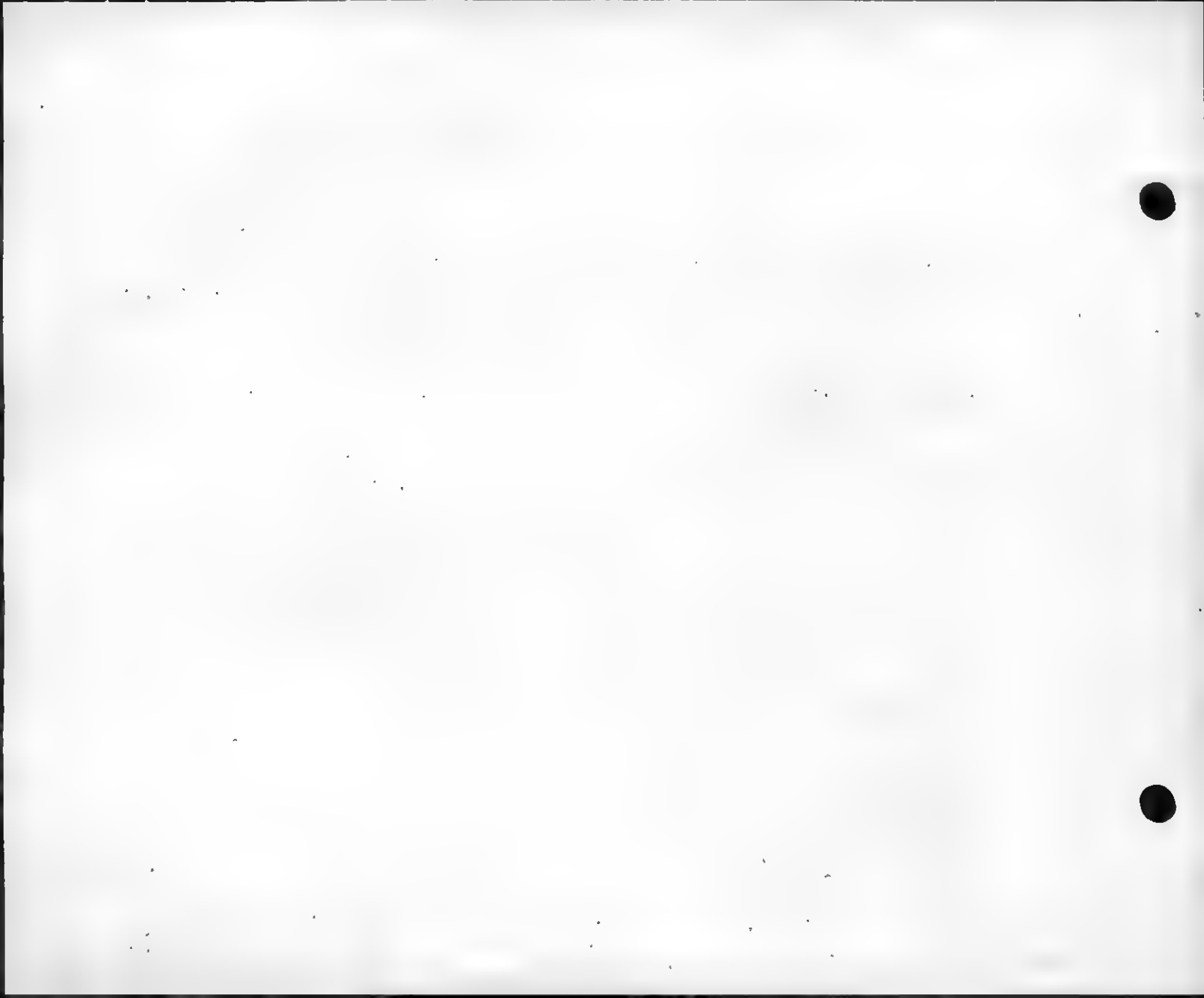


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ALICE				TOLSON	April 6, 1968		2:30pm	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. FUNERAL 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	WHITE		December 16, 1869		98 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
OHIO		U.S.A.				BALTIMORE Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
BALTIMORE		BALTIMORE		TOWSON				103 LINDEN TERRACE #4
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
None				Family records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary infarction, multiple</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary thromboembolism, multiple</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>465 x</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>A dynamic ileus. Acute ulcerative colitis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (1) (this hospital) attended the deceased from <u>March 27</u> , 19 <u>68</u> , to <u>April 6</u> , 19 <u>68</u> , that (2) (we) last saw the deceased alive on <u>April 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (If we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS				
<u>Reynaldo Urjuela-Jomez, M.D.</u>		April 6, 1968		7620 York Road, Towson 4, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)		
Burial		April 18, 1968		Moreland Memorial Park		Parkville, Maryland		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>John Burns Sons, Towson, Md.</u>				DATE APR 10 1968		<u>Charles Judge</u>		

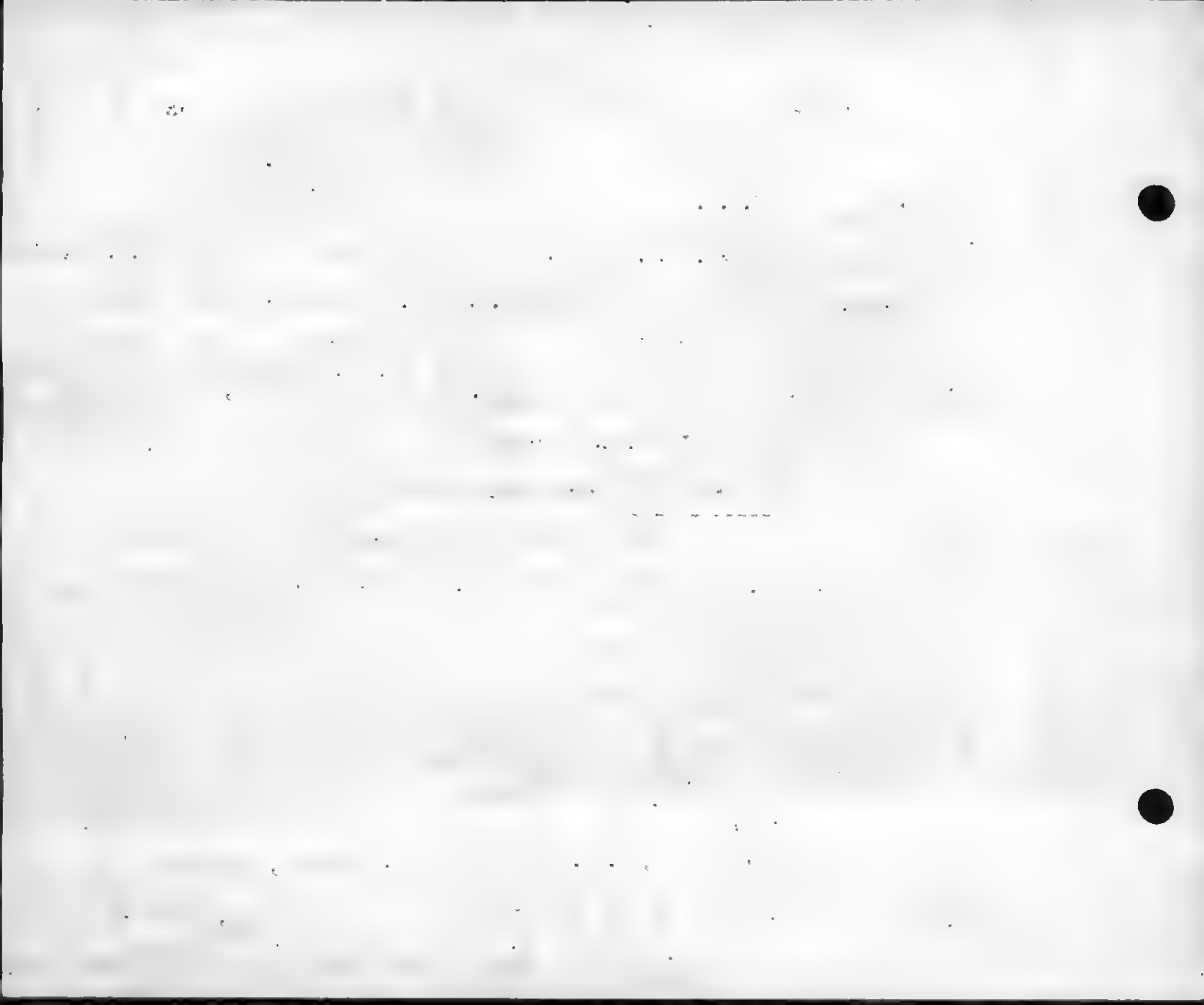


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>													
1. DECEASED NAME (Type or print)		First JOSEPH		Middle FRANK		Last TRUITT (Truitt)		2c. DATE OF DEATH Month 4 Day 16 Year 68			2b. HOUR 6:05AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1/7/93			6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY							
10. CITY OR TOWN OF DEATH FORT HOWARD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET. ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1706 Crystal Avenue					
14. FATHER'S NAME First Joseph Middle Truitt Last Truitt				15. MOTHER'S MAIDEN NAME First Antoinette Middle Small Last Small									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or Unknown <input type="checkbox"/> (If yes give year or date of service) WW I		16b. SOCIAL SECURITY NO 216 16 31 28		17. INFORMANT Mrs WM. F. Kammerer 4120 Parkside CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HOURS			
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF -- (c) CARCINOMA OF COLON AND DUODENAL BULB													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS. CHRONIC BRAIN SYNDROME. OLD PULMONARY TUBERCULOSIS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) VAH FORT HOWARD, MARYLAND		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____									
22a. I certify that (X) (this hospital) attended the deceased from 2/6/68 , 19____, to 4/16/68 , 19____, that (X) (we) lost saw the deceased alive on 4/16/68 , 19____, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) (not) view the body after death.													
22b. SIGNATURE Rodolfo Miro, M.D.								DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/16/68	
22d. PHYSICIAN'S NAME (Type) RODOLFO MIRO, M. D.								22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE April 19,		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR		ADDRESS H. SANDERS & SONS FUNERAL DIRECTORS		25a. REC'D BY REGISTER 1968		25b. REGISTRAR'S SIGNATURE [Signature]							



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VR A15 (4)
25M 1/67

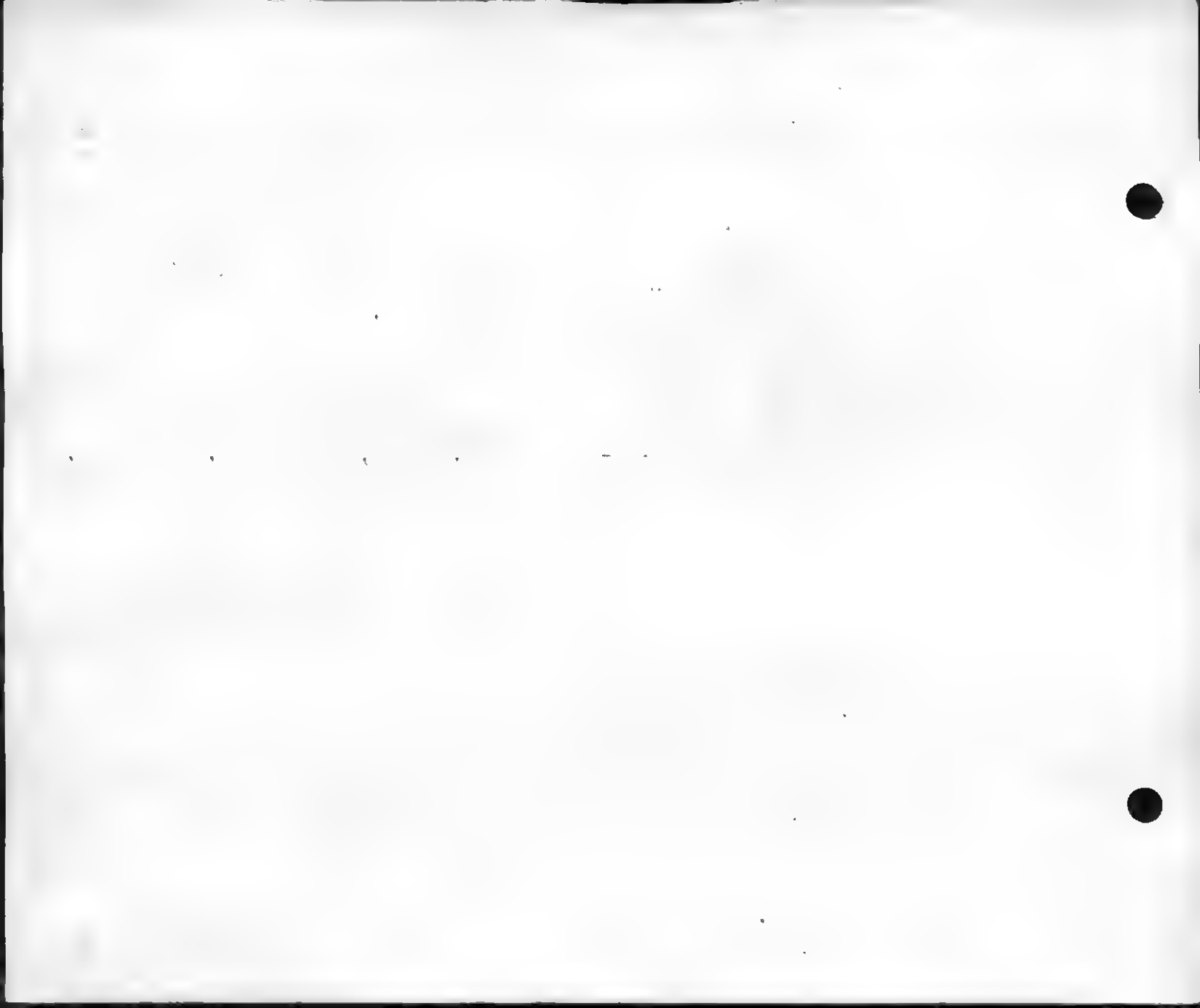
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05412

CERTIFICATE OF DEATH

05-14

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>544 Park Avenue</u>		d. STREET ADDRESS <u>544 Park Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>R.</u> Last <u>Tucker</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 1, 1883</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building Trade</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Ruth Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Peregriny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-20-7334</u>	
17. INFORMANT <u>Mina S. Tucker</u>		Address <u>544 Park Ave., Towson, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>1109</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1960</u> to <u>April 16, 1968</u> , that (I) <u>last</u> saw the deceased alive on <u>April 16, 1968</u> , and that death occurred at <u>6:30 P.</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Laurence C. Post</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/17/68</u>
22c. PHYSICIAN'S NAME (Type) <u>LAURENCE C. POST</u>		22d. ADDRESS <u>6805 York Rd Baltimore 21212 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 19, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 19 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

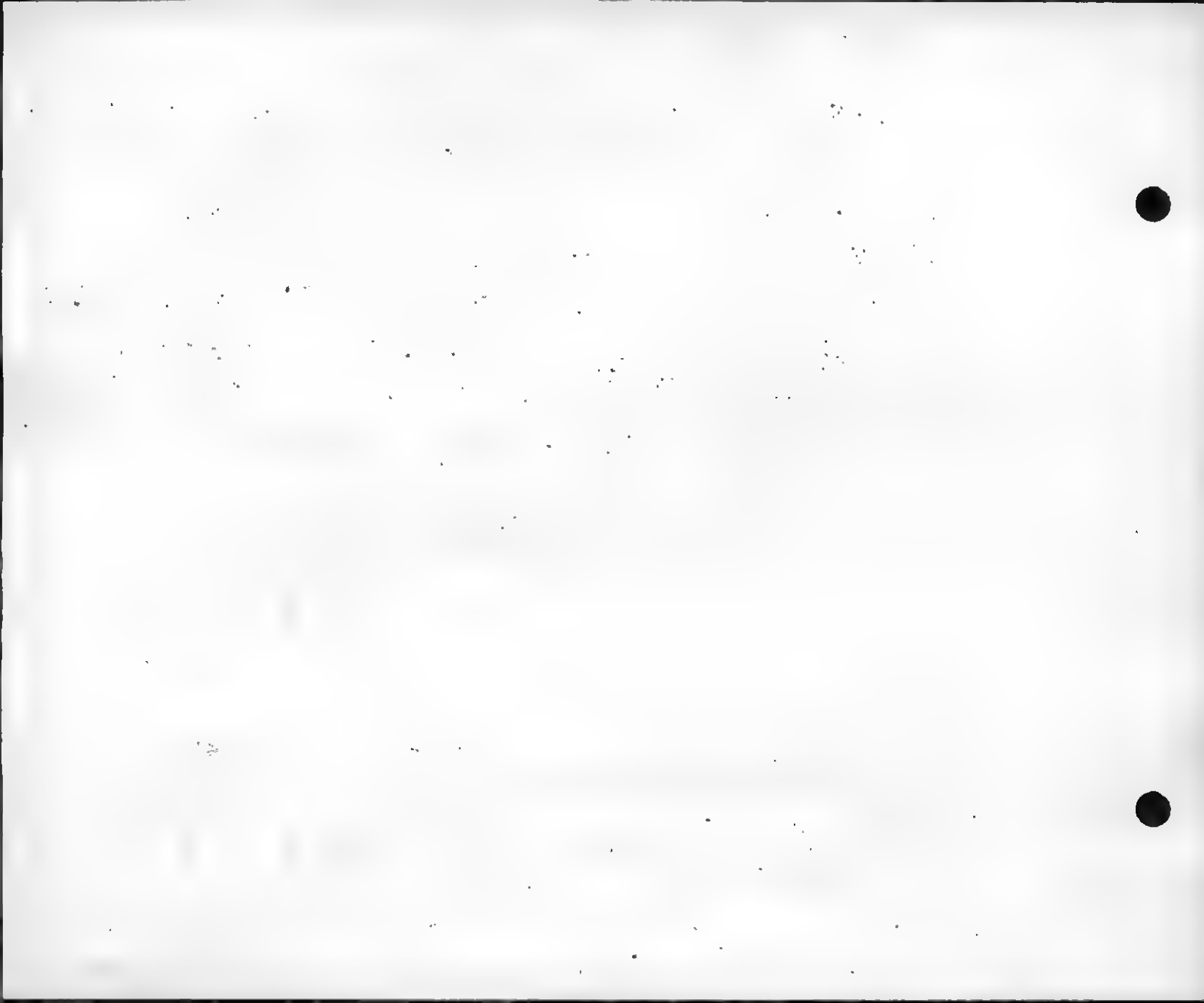


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

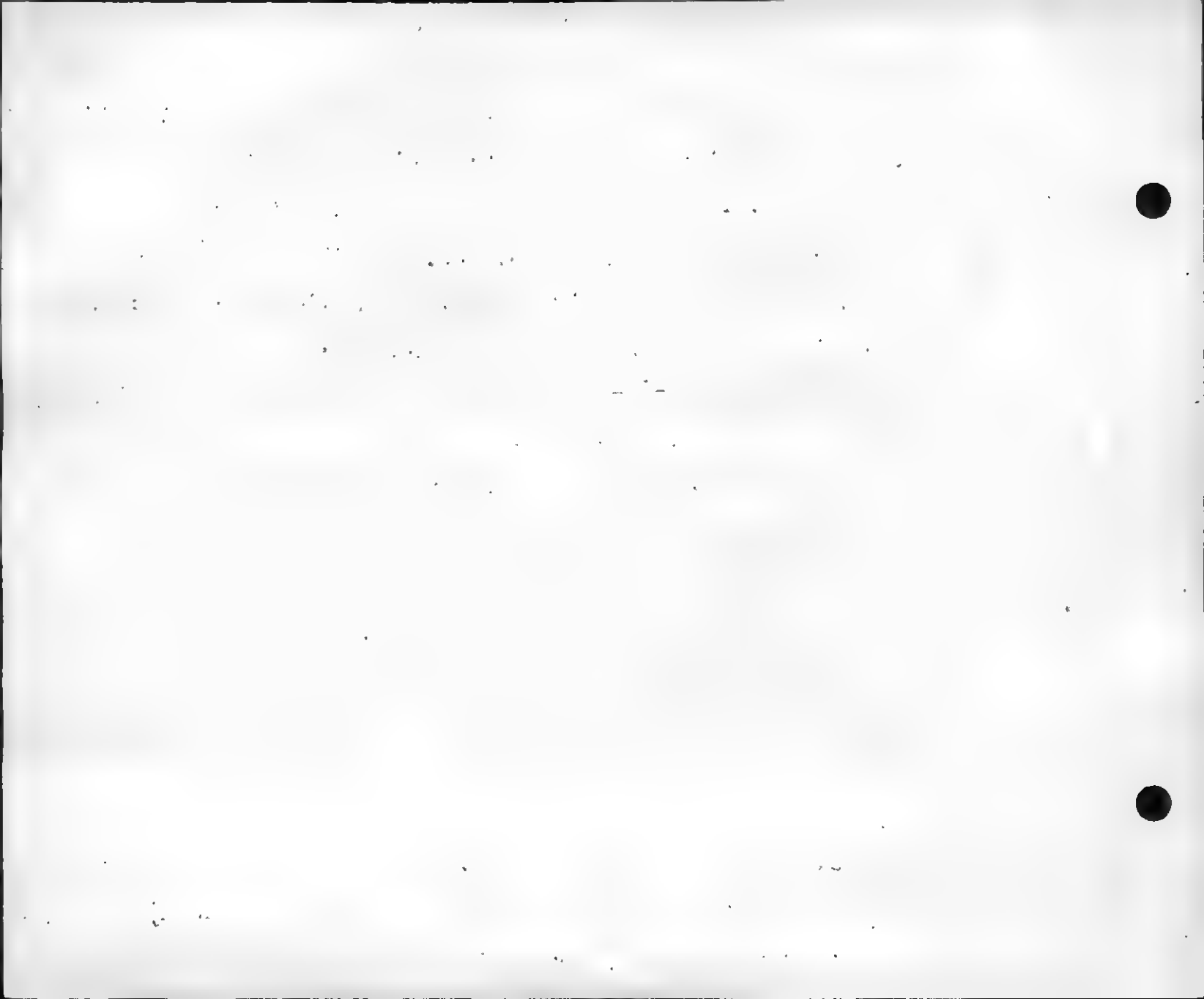
1 DECEASED-NAME (Type or print) AMBRASE			First JOSEPH			Middle VASOLD			Last			2a. DATE OF DEATH Month 4 Day 24 Year 68			2b. HOUR 12M		
3 SEX MALE			4. RACE CAUCASIAN			5 DATE OF BIRTH 4-29-85			6 AGE (In years lost birthday) 82 YRS.			if UNDER 1 YEAR MONTHS DAYS			if UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) BALTO., Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.								
10. CITY OR TOWN OF DEATH TOWSON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.			12a. USUAL OCCUPATION (Kind of work done during most of work ng. life, even if retired) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY PAINTER								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3211 FLEET ST. #24					
14 FATHER'S NAME First I Middle MARTIN Last VASOLD			15 MOTHER'S MAIDEN NAME First WINTERLING Middle - Last MARONICA														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. RAILROAD RET. A-309167			17. INFORMANT MISS MADELINE VASOLD			Address BALTO. 3211 FLEET ST. 21224. MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (b) Udemia																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION																	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED																	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)																	
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19																	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)																	
21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 4-22-19-68 to 4-25-19-68 , that (I) (we) last saw the deceased alive on 4-25-19-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE J. A. DECASTRO DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>																	
22c. DATE SIGNED 4/25/68																	
22d. PHYSICIAN'S NAME (Type) J. A. DECASTRO																	
22e. ADDRESS G.B.M.C.																	
23a. B. BURIAL, CREMATION, REMOVAL (Specify) BURIAL																	
23b. DATE 4-29-68																	
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.																	
23d. LOCATION (City or Town) (County) (State) 7401 GERMAN HILL RD. BA. CO., MD.																	
24. FUNERAL DIRECTOR Charles S. Judge ADDRESS 901 S. CONKLING ST. BALTO., 21224. MD.																	
25a. REC'D BY REGISTRAR APR 26 1968																	
25b. REGISTRAR'S SIGNATURE Charles Judge																	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 00516 13 Film G394 CERTIFICATE OF DEATH 05416 </div>									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b. HOUR	
Theresa			NMI			Vauken		Month 4 Day 7 Year 68 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
Female		White		9/29/78		89 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Yugoslavia		U.S.A.				Baltimore		Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Randallstown			Balto. Co. Gen.			Housework		Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INS OF CITY LIMITS?		13e STREET AND NUMBER	
Md.		Balto.		Randallstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		611 E. Hilton Street, Ave. Chapel Hill, Mrs. Home	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MA DEN NAME First Middle Last						
Joseph Padboy			Gertrude Trimozic						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (known) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			217-54-6297			Baltimore County General Hospital			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c).)									
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. PNEUMONIA</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause: <div style="display: flex; justify-content: space-between;"> <div> (b) <u>1. FRACTURE LEFT HIP</u> </div> <div> (c) </div> </div>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Arteriosclerotic heart disease & diabetes mellitus									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
		NURSING HOME							
22a. I certify that (I) (this hospital) attended the deceased from 4-3-1968, to 4-7-1968, that (I) (we) lost saw the deceased alive on 4-7-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. No accident									
22b SIGNATURE <u>Joseph C. Laredo, MD</u> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED	
22b PHYSICIAN'S NAME (Type) <u>JOSEPH C. LAREDO</u>						22e ADDRESS <u>BALTO. COUNTY GEN. HOSP</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		4-10-68		KALBAUGH		ELK GARDENS WEST VIRGINIA			
24. FUNERAL DIRECTOR <u>Loring Dyck - 8728 Liberty Rd, Balto, Md</u> ADDRESS						25a. REC'D BY REGISTRAR DATE <u>APR 11 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	



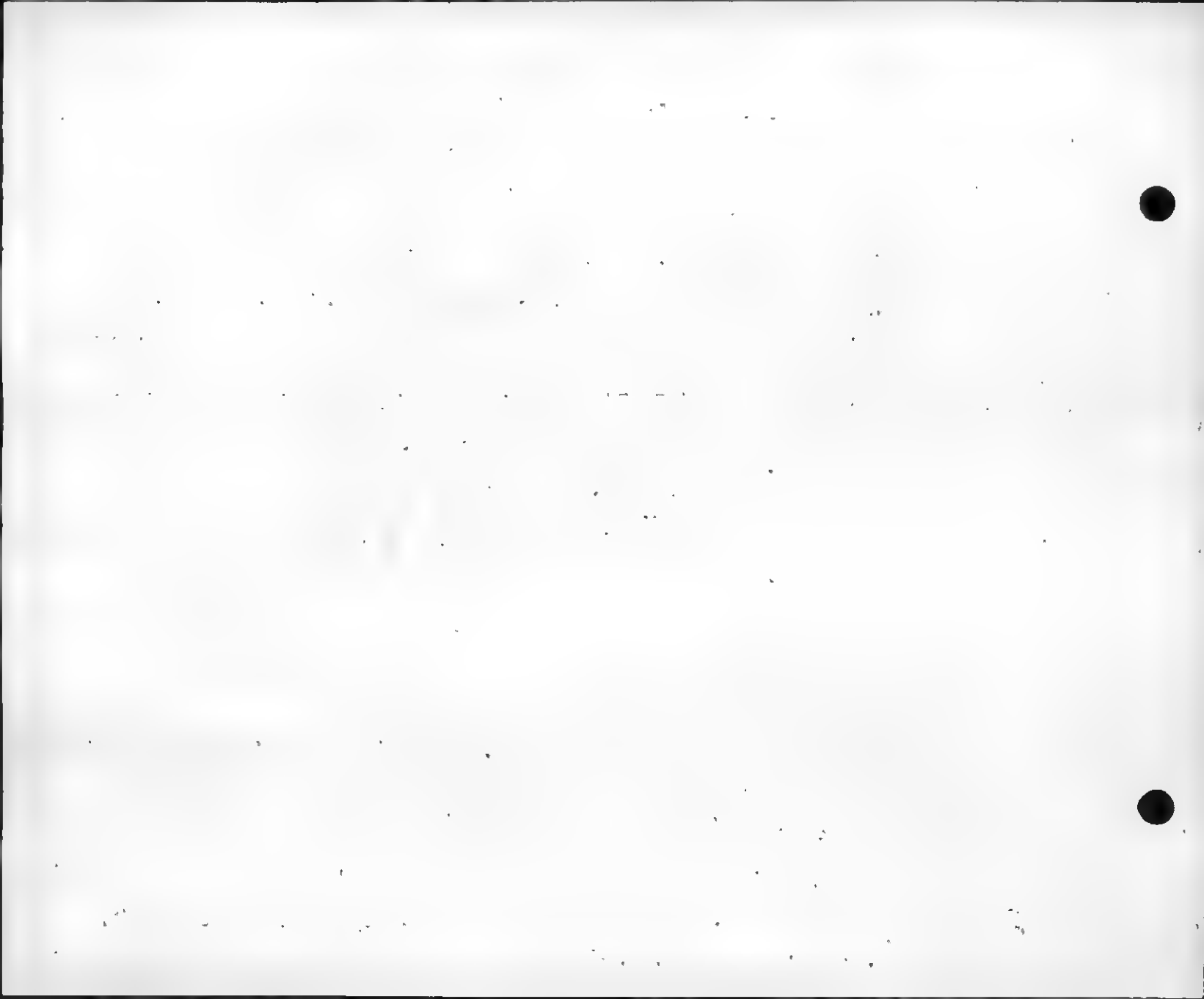
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VR 154 (4)
30M REV 66

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5415
M
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

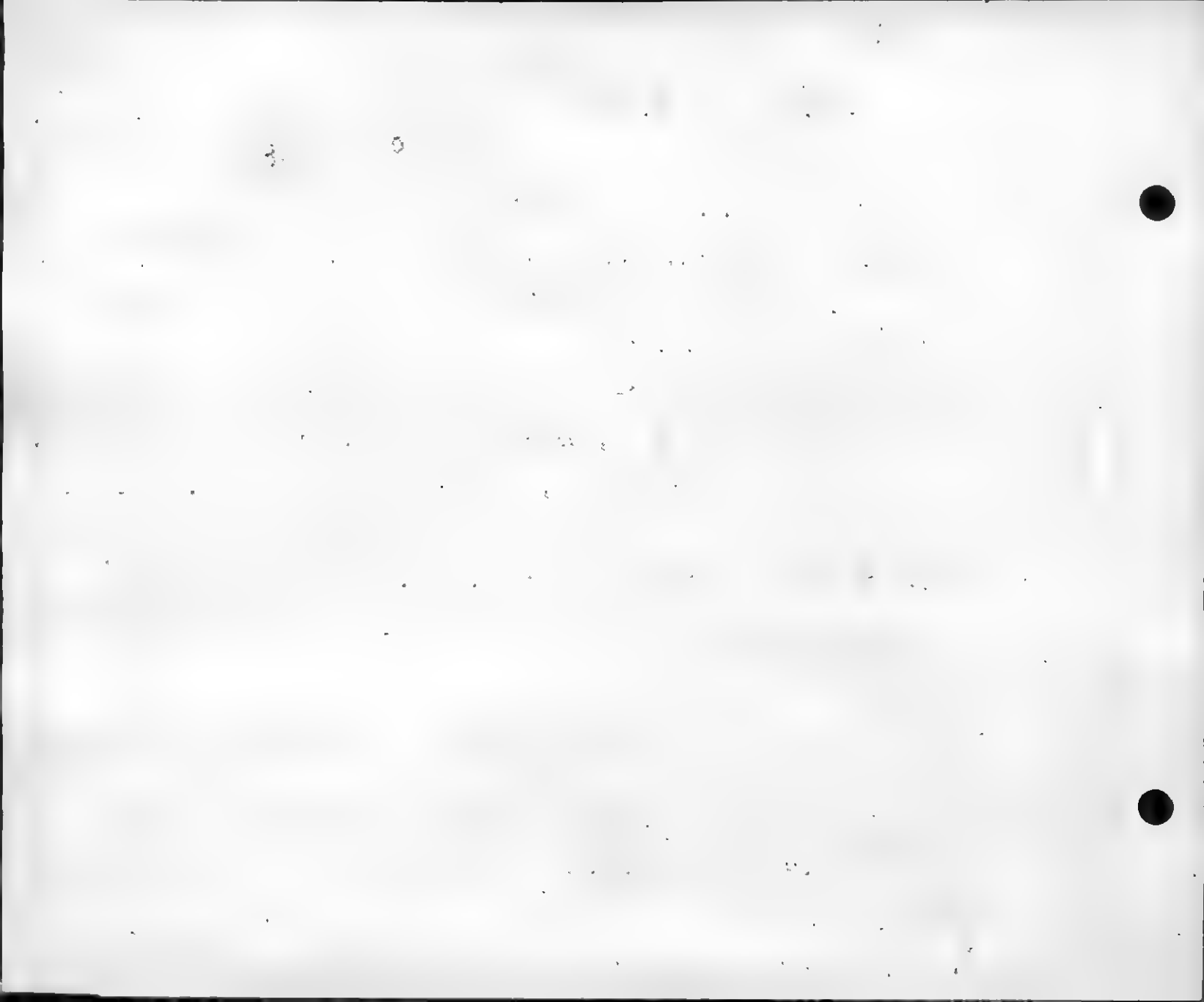
1. DECEASED-NAME (Type or print) Mae (Marie)		First E.		Middle Via		Last Via		2a. DATE OF DEATH Month April Day 13 Year 68		2b. HOUR 7.30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-17-1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS 68 DAYS 68 HOURS 68 MIN.		7. UNDER 24 HRS HOURS 68 MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1907 E. 29th Street			
14. FATHER'S NAME First James Middle Mount Last Mount		15. MOTHER'S MAIDEN NAME First Mary Middle Helfrich Last Helfrich									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 213-01-8982B		17. INFORMANT Address Mrs. Doris V. Muhly, 5427 Purdue Ave. #12							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast 114X DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic to mediastinal DUE TO, OR AS A CONSEQUENCE OF (c) Complete atelectasis ;right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/30/ , 19 68 , to 4/13/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/13/ , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel Lee, M.D.		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-14-68							
22d. PHYSICIAN'S NAME (Type) Samuel Lee, M. D.		22e. ADDRESS 7620 York, Rd., Towson, Md., 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/17/68.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) MARY Alice			Middle Alice Last Vogel			2a. DATE OF DEATH Month April Day 21 Year 1968		2b. HOUR 2:55 MIN P.	
3 SEX Female		4. RACE White		5. DATE OF BIRTH 1/20/1880		6 AGE (In years) 88 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	
10 BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		Md.	
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3000 Moreland Avenue	
14 FATHER'S NAME First George Middle Hall Last Hall			15 MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown						
16a. WAS DECEASED EVER IN ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO. 218-26-2674-D		17. INFORMANT Address Records: Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, right lower lobe, organism / 551.3 DUE TO, OR AS A CONSEQUENCE OF (b) Hiatus Hernia, with reflux esophagitis. DUE TO, OR AS A CONSEQUENCE OF (c) Block. 560.4 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Block. Atherosclerotic Cardiovascular Ht. Dis. with Left Bundle Branch								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days. 10 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 19 Day 19 Year 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/16/68 , 19 68 , to April 21, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE Anthony J. Young, M.D.								22c. DATE SIGNED 4-22-68	
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.								22e. ADDRESS Spring Grove State Hospital	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 4/24/68		23c. NAME OF CEMETERY OR CREMATORY York Road		23d. LOCATION (City or town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Chas F. Evanson		24b. ADDRESS 8802 Hanford Rd		25a. REC'D BY REGISTRAR 100 g. 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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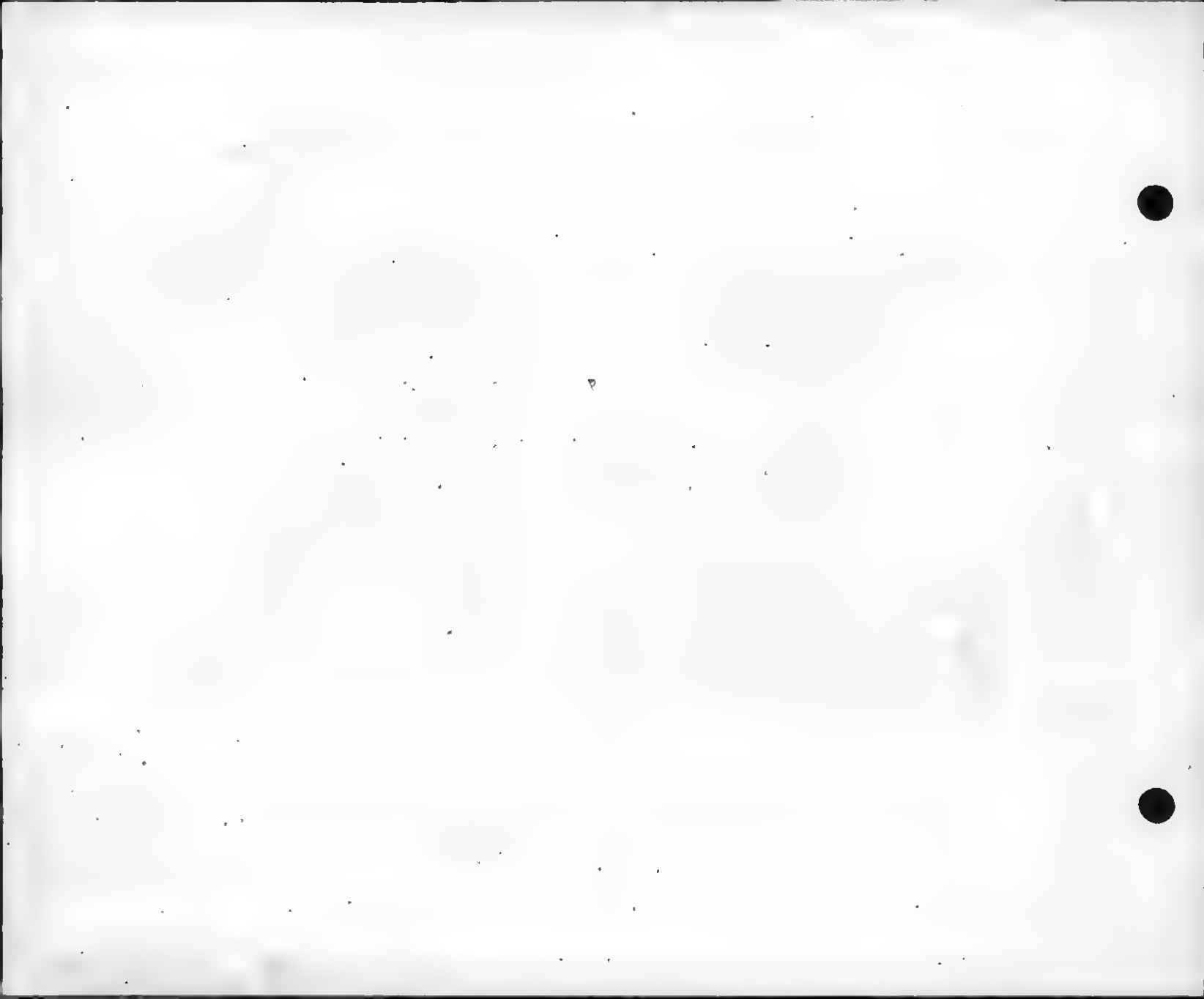
VR A15 (4)
3044 REV 1968

MD 417
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

MD 419

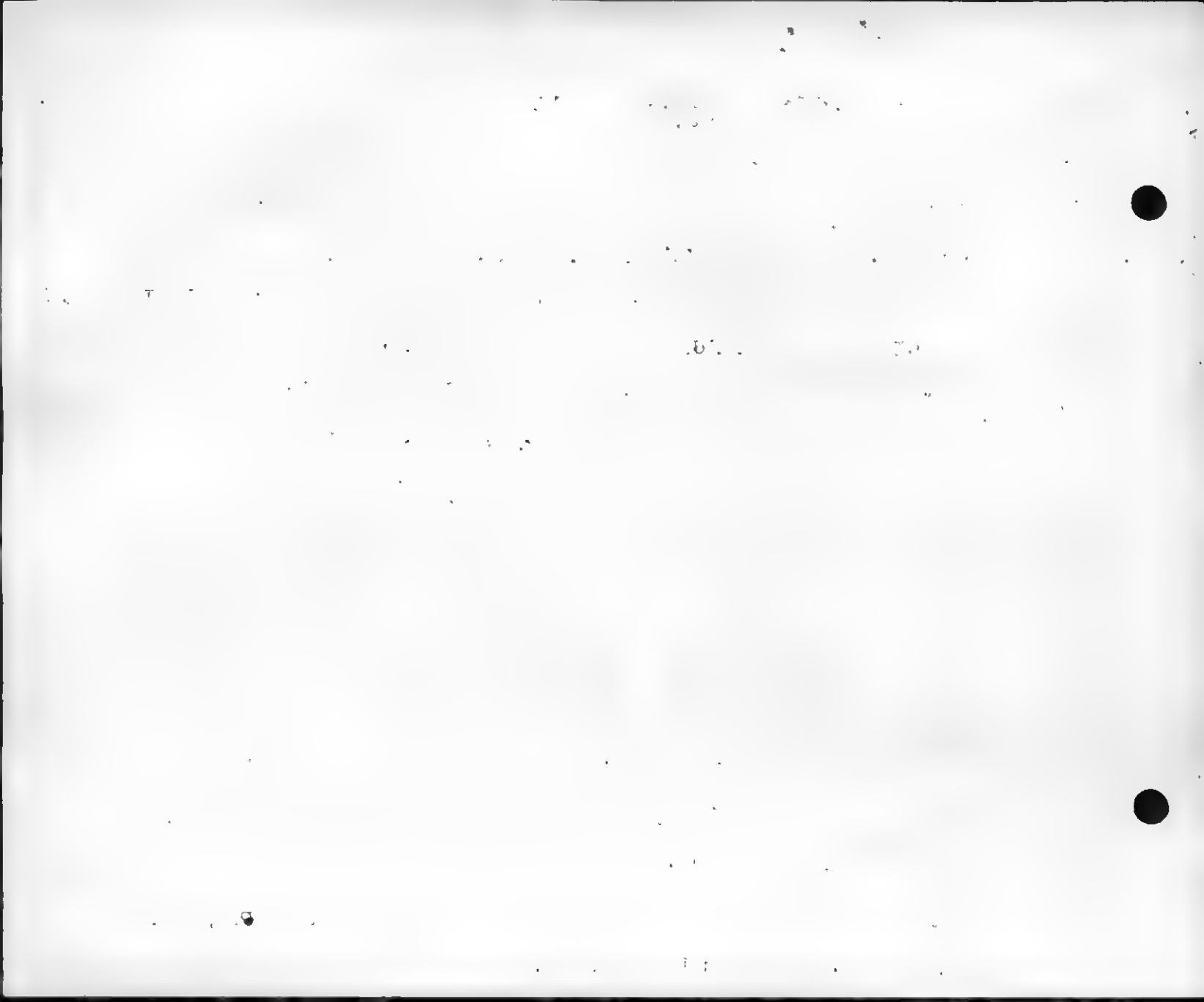
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Jeannette		O.		Votta	April Month 14 Day 1968		3:10 PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years)		IF UNDER 1 YEAR	
Female	White		9-19-1923		47 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Brooklyn						Baltimore Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Baltimore		St. Joseph Hospital		Homemaker				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Maryland		Timonium				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28 Edgemoor Road
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Laurence Oppenheim		Cec Howland						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
		217 12 7173		Larence G. Votta, 28 Edgemoor Rd. 21093				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral confluent bronchopneumonia								
3480 DUE TO, OR AS A CONSEQUENCE OF Amyotrophic lateral sclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 4-7-1968, to 4-14-1968, that (I) (we) last saw the deceased alive on 4-14-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Lawrence Misanik, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		4-15-68
22d PHYSICIAN'S NAME (Type)						22e. ADDRESS		
Lawrence Misanik, M.D.						7620 York Road, Baltimore, Maryland 21204		
23a BURIAL, CREMATION, REINTERMENT		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4-17-1968		Dulaney Valley		Cockeysville, Md.		
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson, Towson, Md. 21204				DATE APR 17 1968		Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last MARION HAYS WALGER						2a. DATE OF DEATH Month Day Year 4 29 68			2b. HOUR 10:30 P M			
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH 2/12/95			6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS 13		IF UNDER 24 HRS. HOURS MIN. 10:30	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.						
10. CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALT. MED. CENT.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY 1		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 3206 PARKSIDE DRIVE				
14. FATHER'S NAME First Middle Last WILLIAM LAZARUS COSTEN				15. MOTHER'S MAIDEN NAME First Middle Last BEULAH INEZ HAYS Hayes								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 216-05-2308		17. INFORMANT Address PATIENT'S CHART								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Respirators failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>et al. Corvex</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> , 19 <u>68</u> , to <u>4-29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-30 P.M. 4-29-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Rahim Bassiri</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-29-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Rahim Bassiri</u>						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/3/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks West Inc Balt. Md. 21228						25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



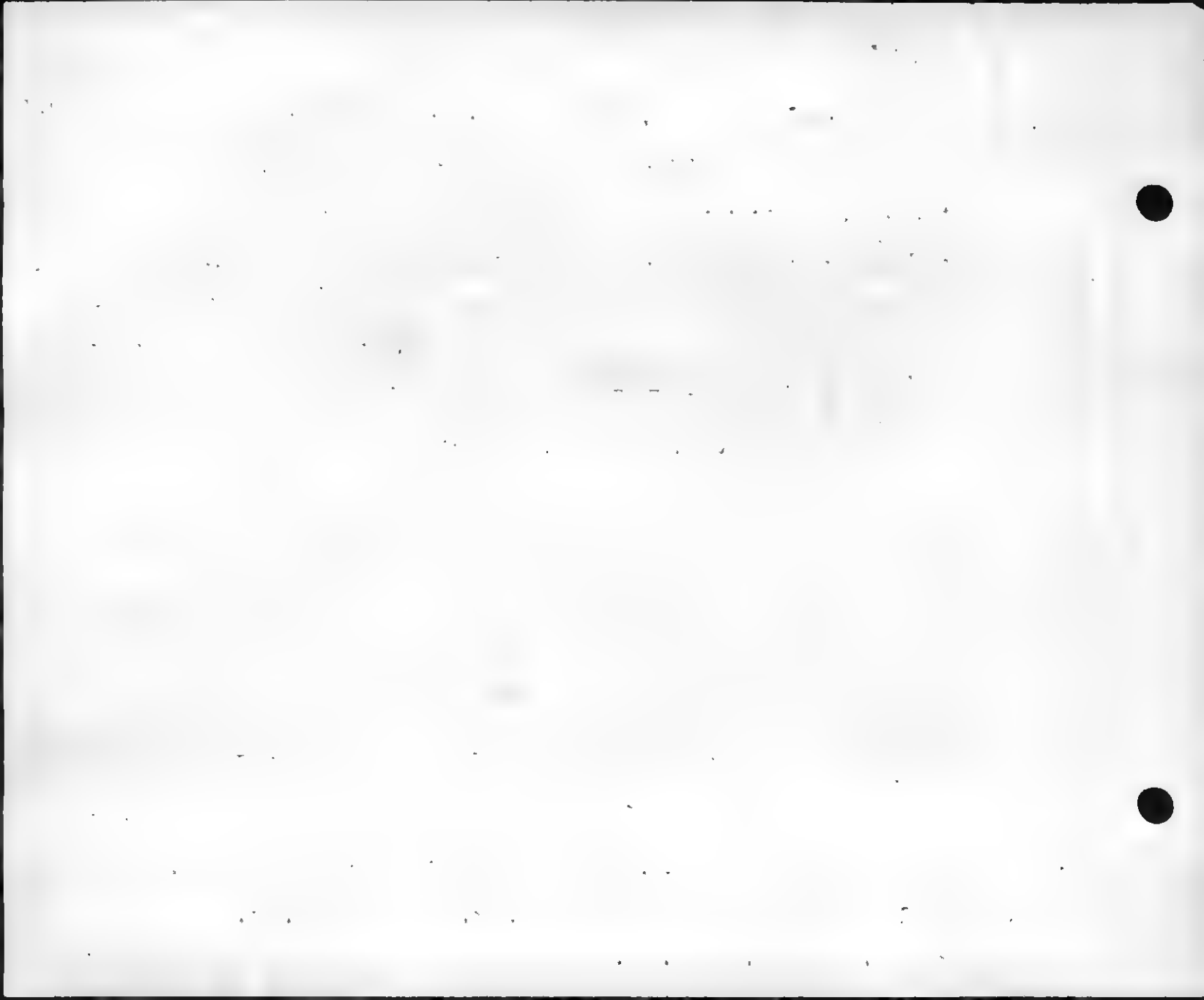
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Donald Middle Eugene Last Ward			2a. DATE OF DEATH Month April Day 9 Year 68		2b. HOUR 4:40 P
3. SEX Male	4. RACE White	5. DATE OF BIRTH 8-25-29		6. AGE (In years lost birthday) 38 YRS	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Baltimore	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH (Baltimore) Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gas Station attendant	12b. KIND OF BUSINESS OR INDUSTRY Station Owner	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Baltimore	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4831 Truesdale Avenue	
14. FATHER'S NAME First Eugene Middle Ward Last Ward		15. MOTHER'S MAIDEN NAME First Nellie Middle Pangle Last Pangle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (unknown) <input type="checkbox"/> Korean (If yes give dates of service)		16b. SOCIAL SECURITY NO. 214-24-8906	17. INFORMANT Nancy Ward Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured anterior communicating artery 442 X DUE TO, OR AS A CONSEQUENCE OF aneurysm-stress ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from 3-30 , 19 68 , to 4-9-68 , 19 68 , that (2) (we) last saw the deceased alive on 4/9/68 , 19 68 , and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Juan Gan		22c. DATE SIGNED 4/9/68		22d. PHYSICIAN'S NAME (Type) Juan Gan, M.C.	
22e. ADDRESS 7620 York Rd., Towson, Md.		22f. ADDRESS			
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE 4/13/68	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Balto. Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

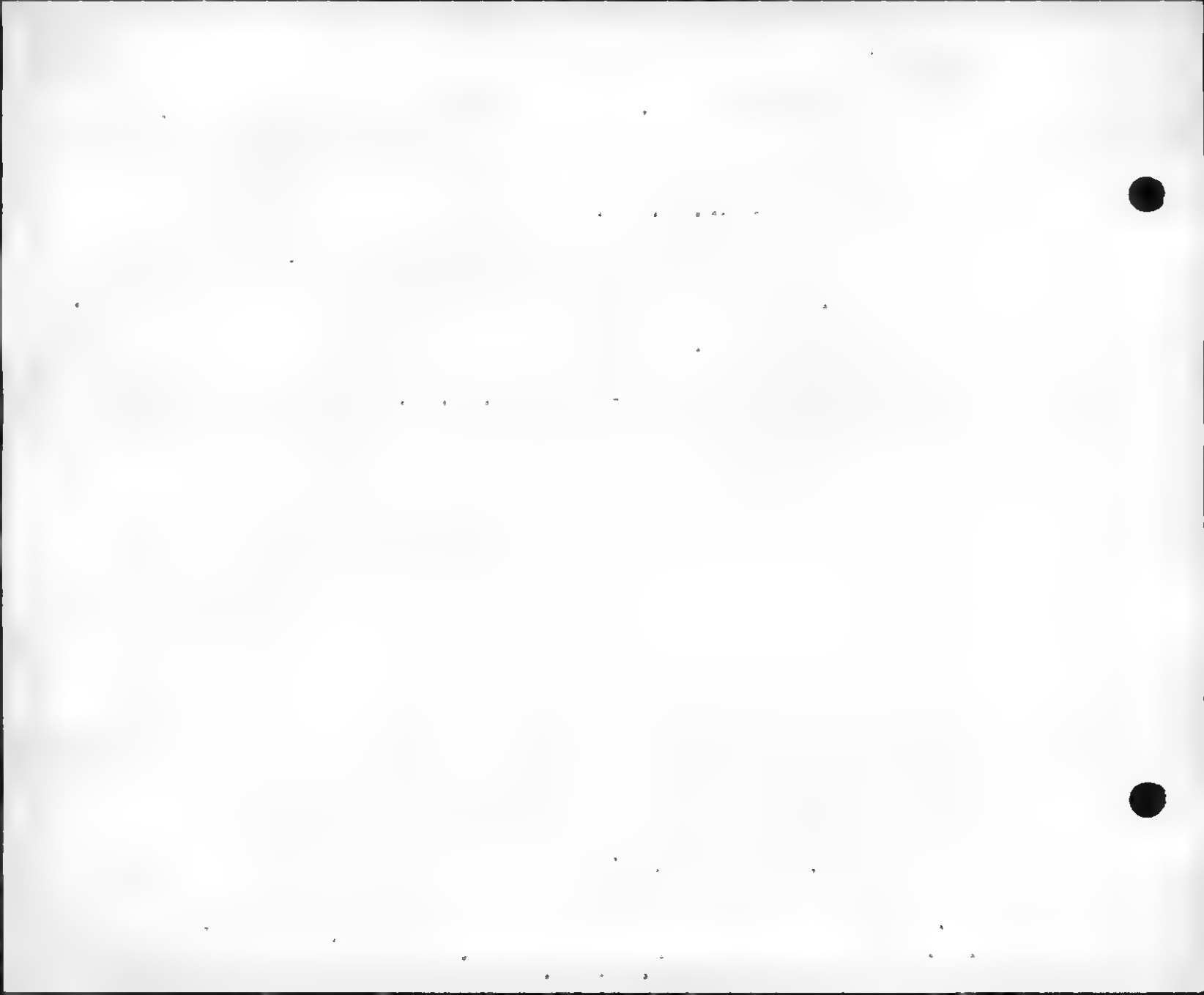
CERTIFICATE OF DEATH

512

1. DECEASED NAME (Type or print) Florence G. Warfield			2a. DATE OF DEATH Month April Day 10 Year 1968			2b. HOUR 11A M			
3. SEX F		4. RACE W		5. DATE OF BIRTH 10/16/1878		6. AGE (In years last birthday) 89 YRS.		7. IF UNDER YEAR MONTHS 11 DAYS 17 HOURS 11 MIN	
7a. BIRTHPLACE (State or foreign country) Prince Frederick, Md. (U.S.A.)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Baltimore 21212		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Armcast Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Public Schools		12b. KIND OF BUSINESS OR INDUSTRY Teaching			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Ruxton		13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e. STREET AND NUMBER 1501 Carrollton Ave.	
14. FATHER'S NAME First Andrew Middle J. Last Gill			15. MOTHER'S MAIDEN NAME First Kate Middle Luman Last Luman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-44-7531		17. INFORMANT Mrs. D. H. Hamilton		Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis (b) 10 days (c) 10 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/10/68 to 4/11/68 , that (we) last saw the deceased alive on 4/10/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d'd) (did not) view the body after death.									
22b. SIGNATURE Charles F. O'Donnell				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/11/68	
22d. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell				22e. ADDRESS 7501 York Road					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/13/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City or Town) (County) (State) Cumberland, Maryland			
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REG. STRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68
304 REV 11-68

4
1
65421
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) LINN REANEY WARFIELD			2a. DATE OF DEATH Month 4 Day 10 Year 68			2b. HOUR 9:50 P.	
3 SEX FEMALE		4 RACE CAU.		5. DATE OF BIRTH 1-16-09		6. AGE (in years lost birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md	
10. CITY OR TOWN OF DEATH TOWSON, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTIMORE MED.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN RUXTON		13d. INSIDE CITY - MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 27 MURRAY HILL CIRCLE		14 FATHER'S NAME First JAMES Middle - Last REANEY		15 MOTHER'S MAIDEN NAME First JULIA Middle - Last VON RIESEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 213-38-5456		17. INFORMANT ADMISSION SHEET		Address G.B.M.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH) BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 12/1/1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 29 Jan., 1968 , to 4, 10, 1968 , that (I) (we) last saw the deceased alive on 9:50 4/10/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maghami M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-10-68	
22d. PHYSICIAN'S NAME (Type) MAGHAMI M.D.		22e. ADDRESS Greater Baltimore Medical Center 6701 N. Charles Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-13-68		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd.		25a. REC'D BY REGISTRAR DATE APR 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05424

1. DECEASED NAME (Type or print) WATTS, MILTON A.			2a. DATE OF DEATH Month 4 Day 27 Year 68			2b. HOUR 7 P M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 12-19-1900		6 AGE (in years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) USA MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md	
10. CITY OR TOWN OF DEATH Randalltown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retail Grocer		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE MD.		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 3800 Lochearn Drive	
14. FATHER'S NAME First Middle Last (Deceased) Richard A. Watts			15. MOTHER'S MAIDEN NAME First Middle Last Eleanor French				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 705-10-6474		17. INFORMANT Mrs. Anna A. Watts Address 3800 Lochearn Drive Balto. Md. 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac ARREST 1621 DUE TO, OR AS A CONSEQUENCE OF (b) ASHD, pulmonary congestion DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma, left upper lobe							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes weeks months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jose A. Raquel Jr. M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 4/27/68	
22d. PHYSICIAN'S NAME (Type) JOSE A. RAQUEL JR. M.D.						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/30/68		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR Roning Byers, 8728 Liberty Rd. Randallstown Md.				25a. REC'D BY REGISTRAR DATE May 1 1968		25b. REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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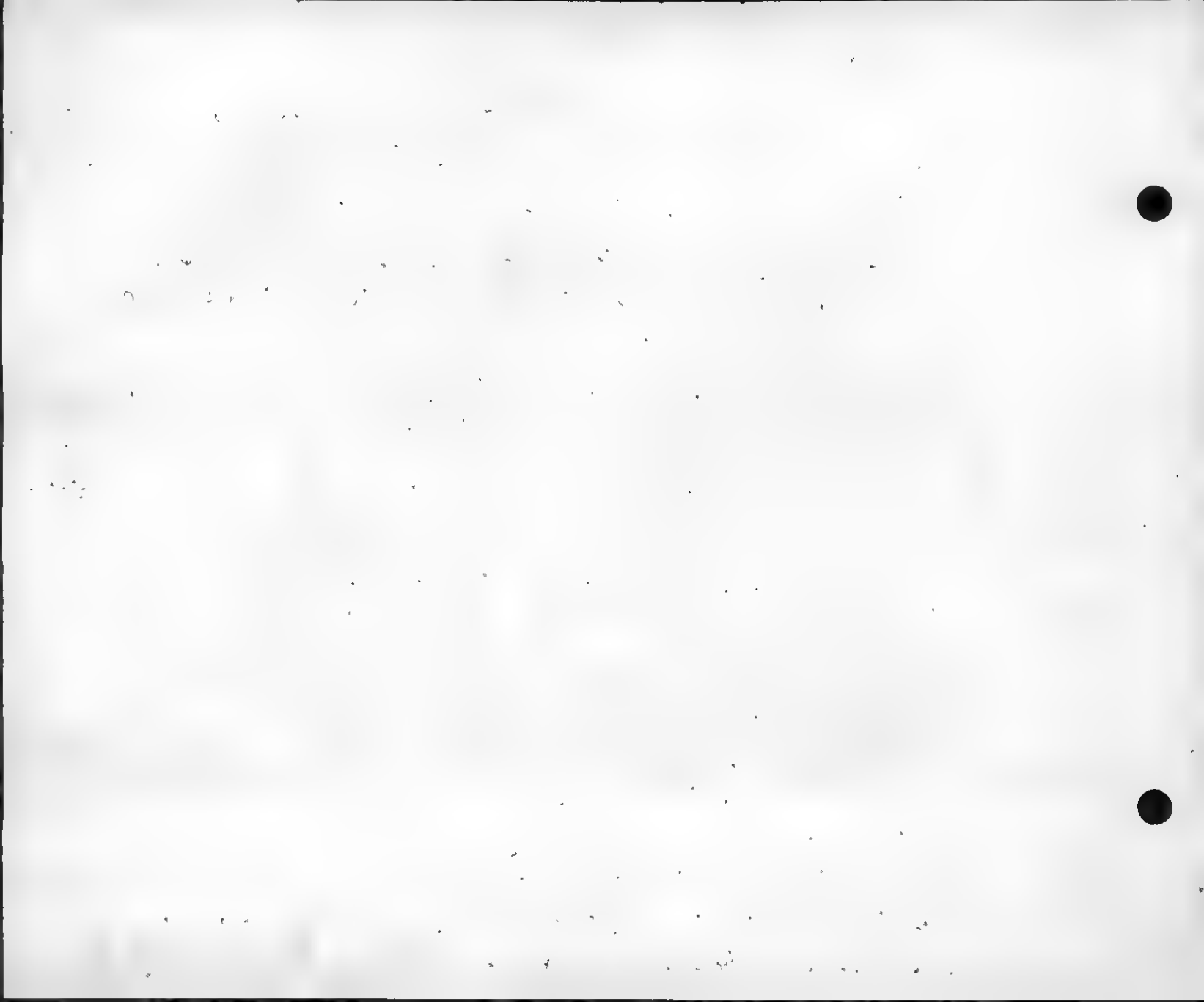
05423

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05425

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P M	
Andrew				Webster	April 4, 1968		4:30 P	
3 SEX	4 RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
male	white	May 6, 1887			80			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD.	U.S.A.			Baltimore Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Parkville		3337 Garnet Road			Ret. Chief Operating Engr.			
13a. USCA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIM 1ST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Md.		Baltimore	Parkville		3337 Garnet Road			
14. FATHER'S NAME		First	Middle	Last	5. MOTHER'S MAIDEN NAME		First	Middle Last
Andrew J. Webster					Diana A. Tolly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO		220-07-7671		MR. Wayne W. Webster - Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure + 12 y Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 20 days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Abdominal Aortic Aneurysm.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (the hospital) attended the deceased from 1946 , 1946, to April 3, 1968, that (I) (we) last saw the deceased alive on April 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
Thomas J. Brennan M.D.		5 April 1968			Thomas J. Brennan, M.D.			
22e. ADDRESS		22f. ADDRESS						
		5217 Harford Road Balto Md 21214						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		4/8/68	Parkwood Cemetery			Baltimore, Md.		
24. FUNERAL DIRECTOR		ADDRESS			25a. PREPARED BY REGISTRAR		25b. REGISTERED SIGNATURE	
Leonard J. Ruck, Inc Baltimore, Md.					APR 9 1968		John Judge	



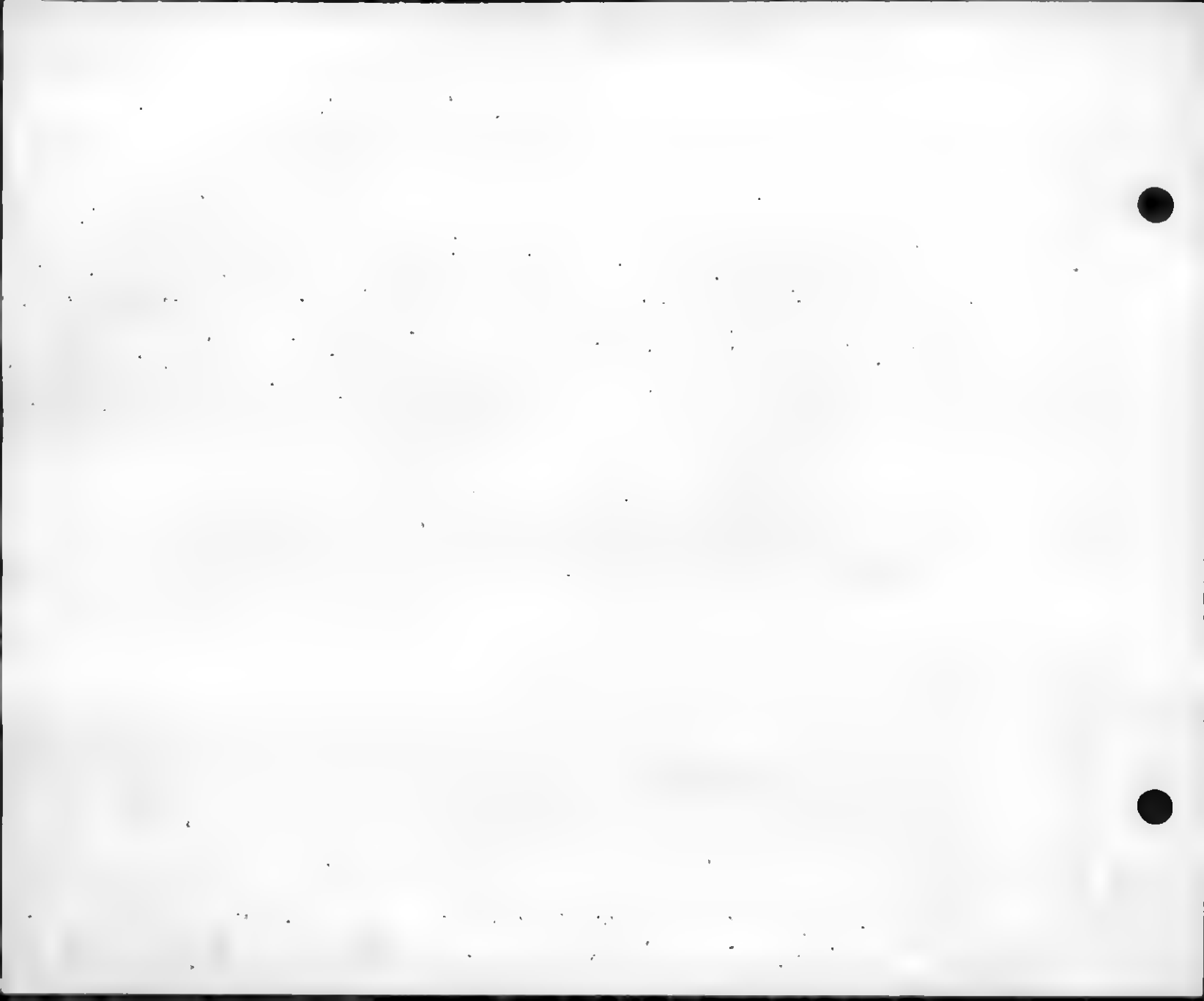
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-1
304a REV 1-68

MD 424
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <u>First</u> <u>Helen</u> <u>Middle</u> <u>K.</u> <u>Last</u> <u>West</u>		2a. DATE OF DEATH <u>April</u> Month <u>11</u> Day <u>1968</u> Year		2b. HOUR <u>M</u>	
3. SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>July 9, 1904</u>	
6 AGE (in years last birthday) <u>63</u> YRS.		F. UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>	
7a BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Baltimore</u> Md		10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>3626 Forest Hill Rd</u>	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY		13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>Balto.</u>	
13b COUNTY <u>Balto.</u>		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <u>3626 Forest Hill Rd</u>		13f ZIP CODE <u>21204</u>		14. FATHER'S NAME <u>First</u> <u>John</u> <u>Middle</u> <u>H.</u> <u>Last</u> <u>Reich</u>	
15 MOTHER'S MAIDEN NAME <u>First</u> <u>Sadie</u> <u>Middle</u> <u>Z.</u> <u>Last</u> <u>Miller</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>NONE</u>	
17 INFORMANT <u>Mr. Edwin H. Reich</u> Address <u>Baltimore</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>410.7</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis of Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs -</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Resident of Baltimore</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. <u>19</u> Month <u>July</u> Day <u>10</u> Year <u>1968</u>	
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d INJURY OCCURRED <u>While</u> <input type="checkbox"/> <u>Not while</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>at work</u> <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	
21f LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>		22a. I certify that (I) (this hospital) attended the deceased from <u>July 9, 1937</u> , to <u>April 11, 1968</u> , that (I) (we) lost saw the deceased alive on <u>April 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <u>[Signature]</u> DEGREE <u></u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>4-11-68</u>		22d. PHYSICIAN'S NAME (Type) <u>Dr. Leon A. Kochman</u>	
22e ADDRESS <u>1217 N. Calvert St</u>		23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/13/68</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Inwood Ridge</u>		23d LOCATION (City or Town) <u>Jacksonville</u> (County) <u>Me</u> (State) <u></u>		24 FUNERAL DIRECTOR <u>Loring Byers</u> ADDRESS <u>8728 Liberty Road</u>	
25a REC'D BY REGISTRAR <u></u> DATE <u>APR 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

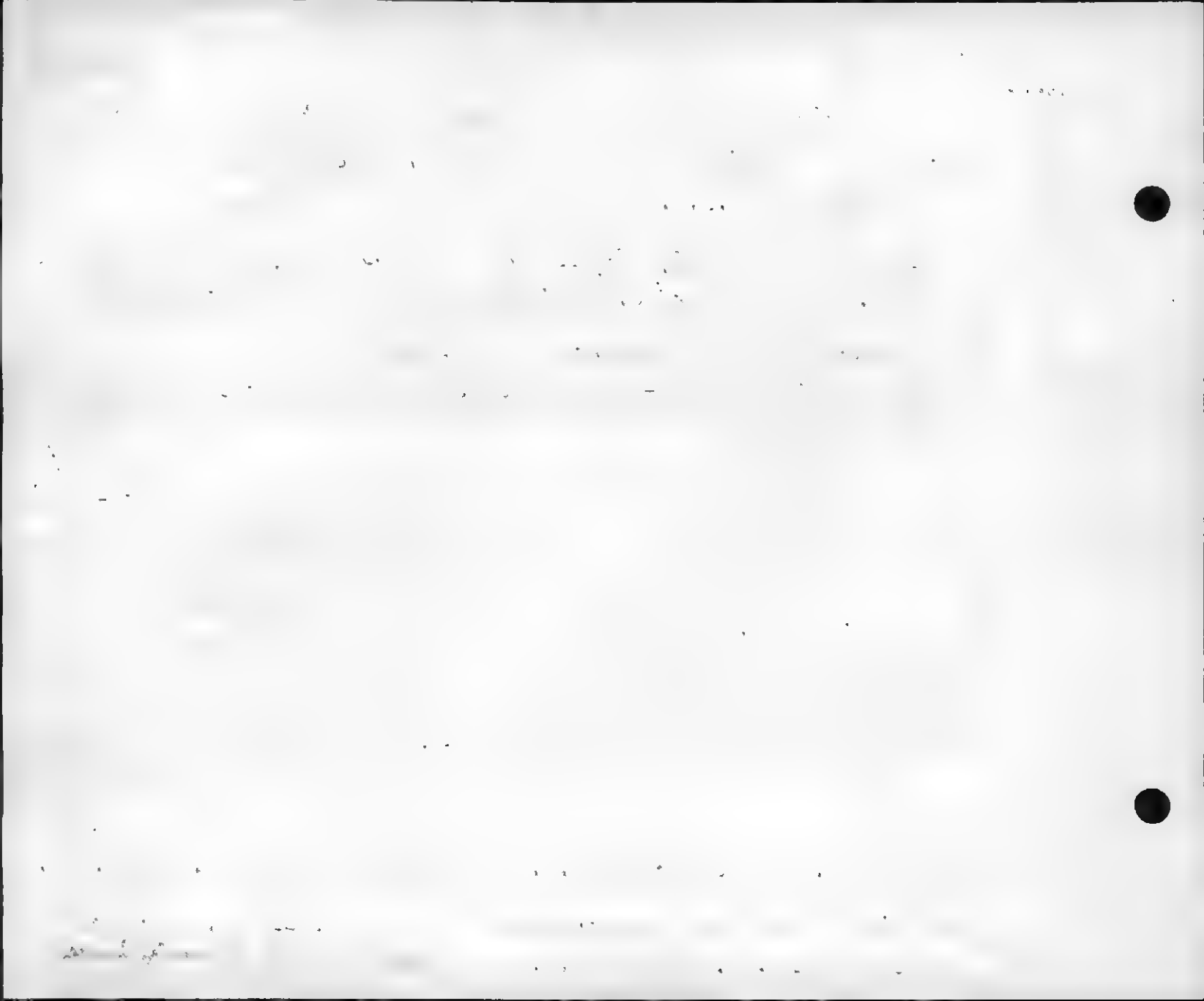
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 105 (14)
30M REV. 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Margaret</i> First <i>West</i> Middle Last			2a. DATE OF DEATH Month <i>April</i> Day <i>14</i> Year <i>1968</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>March 31, 1898</i>		6. AGE (In years last birthday) <i>70</i> YRS.	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore</i> Md.		
10. CITY OR TOWN OF DEATH <i>Carney</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>9404 Ridgely Rd</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housekeeper</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>
13a. U.S.A. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Balto.</i>	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>9404 Ridgely Rd</i>	
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Lambdin</i> Last		15. MOTHER'S MAIDEN NAME First <i>Minnie</i> Middle <i>?</i> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>None</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>212-09-3423</i>		17. INFORMANT <i>Dr. Fred West</i> Address <i>Same</i>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rectal fissure + hemorrhoids</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>Dec. 67</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>71</i>					
19a. DATE OF OPERATION <i>2-21-68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>for incision - 0.2.0</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-68</i> , 19 <i>68</i> , to <i>1-15-68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-12-68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Wallace Walker M.D.</i>			22c. DATE SIGNED <i>2-16-1</i>		
22d. PHYSICIAN'S NAME (Type) <i>W. Wallace Walker M.D.</i>			22e. ADDRESS <i>Medical Arts Bldg. Balto. Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>4/17/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR <i>Leonard J Ruck Inc. Baltimore, Md</i>			25a. REC'D BY REGISTRAR DATE <i>APR 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MEDICAL CERTIFICATE ON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



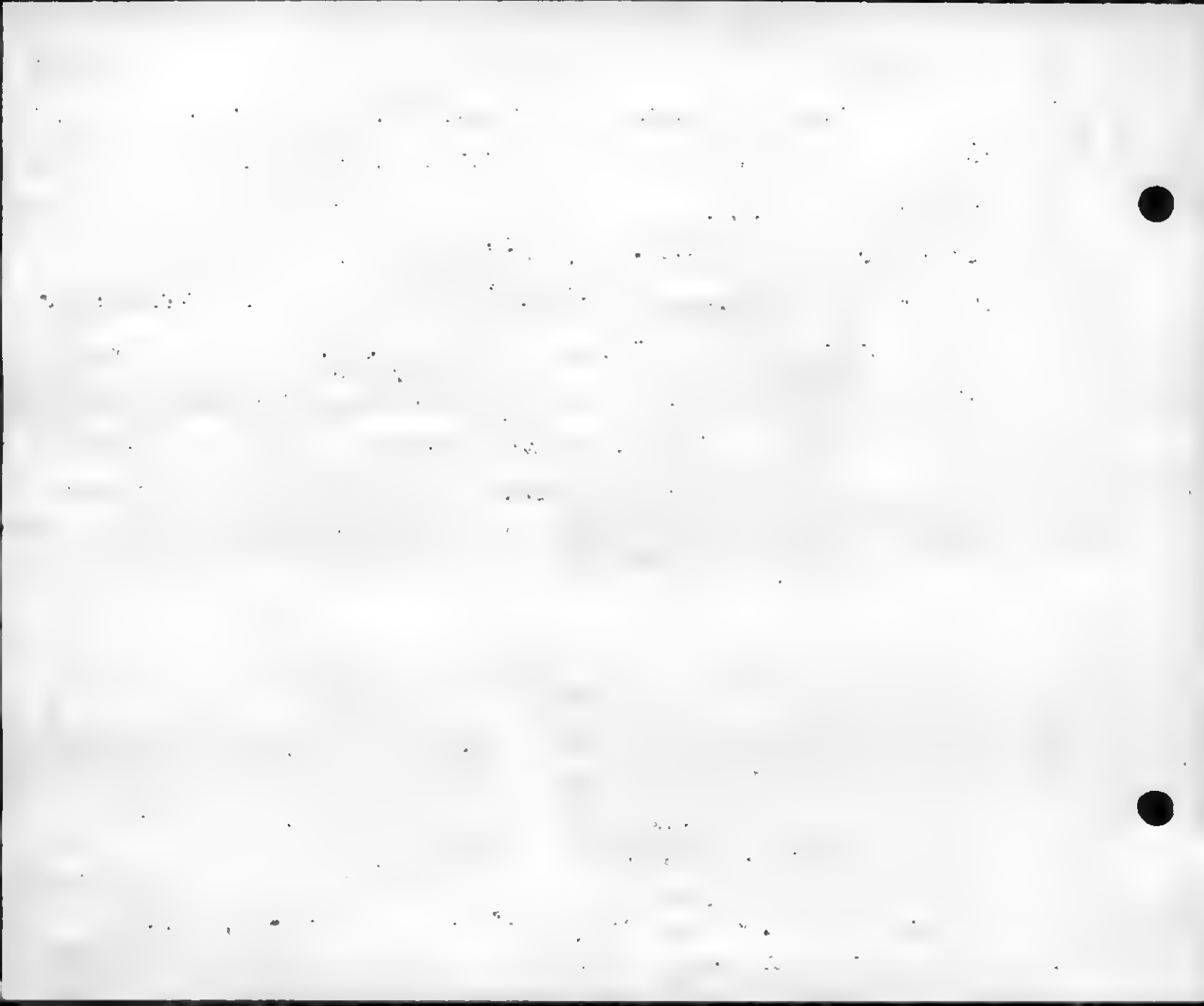
MEDICAL CERTIFICATION

18

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) RUPERT HALL WILLIAMS SR.			2a. DATE OF DEATH Month APRIL Day 26 Year 1968			2b. HOUR 5:45 PM	
3. SEX MALE		4. RACE NEGROID		5. DATE OF BIRTH JANUARY 12, 1896		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) VETERANS ADMINISTRATION HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) COOK		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 133 E. CHESAPEAKE AVENUE		14. FATHER'S NAME First HORATIO Middle WILLIAMS Last WILLIAMS		15. MOTHER'S MAIDEN NAME First AUGUSTA Middle JOHNSON Last JOHNSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 217 05 6288		17. INFORMANT VA HOSPITAL Address CLINICAL RECORDS, FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 DAYS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1101 DIABETES MELLITUS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/14/68 , 19__, to 4/26/68 , 19__, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 4/26/68 , 19__, and that in XXXX (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) XXXX view the body after death.							
22b. SIGNATURE Alfonso A. Lopez				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 26 68	
22d. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.				22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5/1/68		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Wm CHATMAN FUNERAL HOME, 1701 MCCULLOH ST				25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

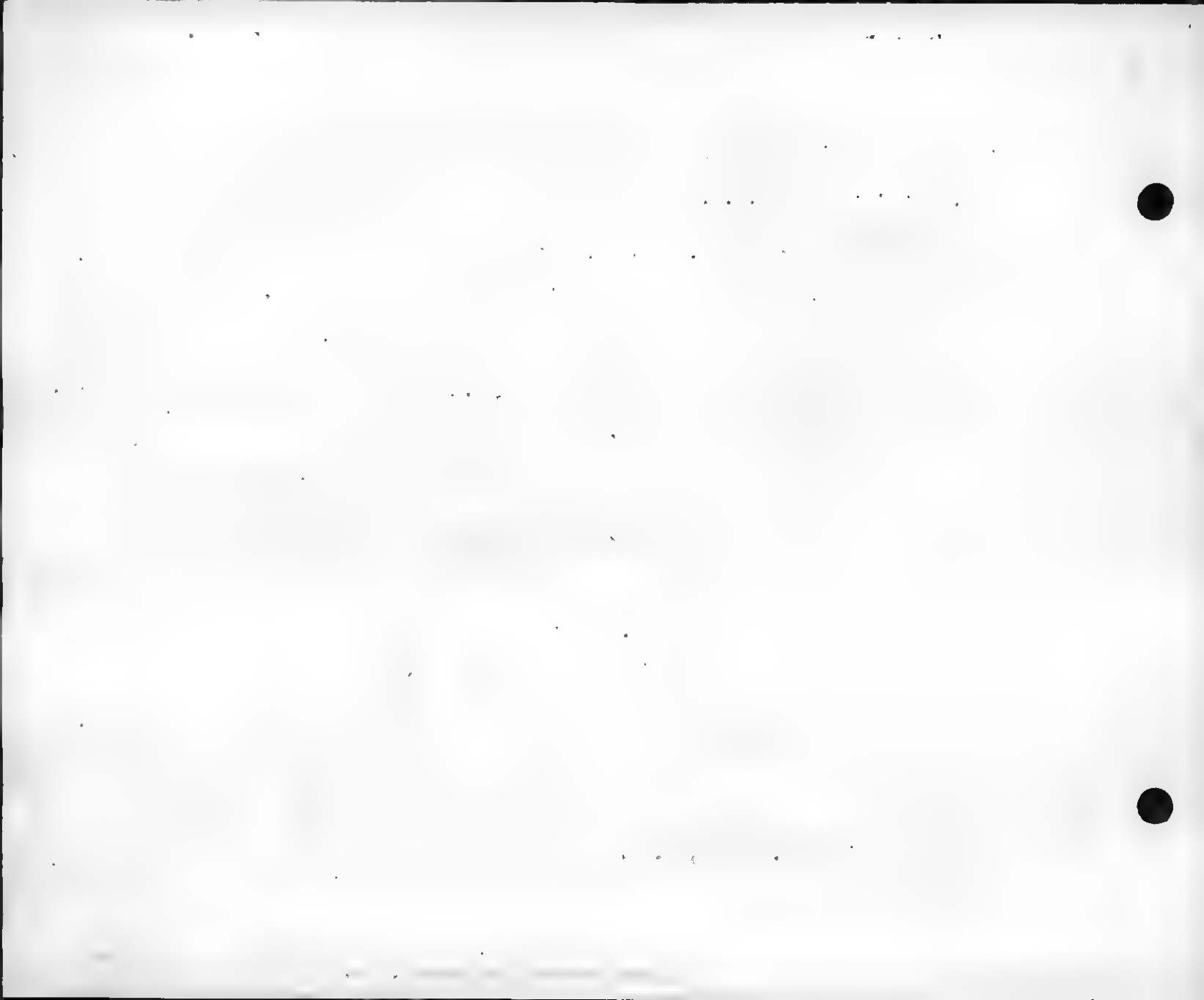


FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201- MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF OF ESTI DEATH MATED				Month	Day	Year	2b HOUR
WILLIE			-		WILLIAMS	4				2	1968	4:30A	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS	8 UNDER 24 HRS HOURS	9	10	11	12	13	14	15	
MALE	NEGRO	5/9/22	45										
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			2d HOUR	
North Carolina			U.S.A.						BALTIMORE COUNTY,			4:30A	
10 CITY OR TOWN OF DEATH Baltimore County			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Vet. Adm. Hospital			12a USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) Mason			12b KIND OF BUSINESS OR INDUSTRY Construction				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER	
Maryland			BALTIMORE						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			220 N. Stricker Street	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last		
WILLIE			-		WILLIAMS	GENEVA					ROBINSON		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
YES			WW II			241 24 94 69			CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												UNKNOWN	
837X													
DUE TO, OR AS A CONSEQUENCE OF													
Cerebral contusions and subarachnoid hemorrhage													
DUE TO, OR AS A CONSEQUENCE OF													
Diffuse cerebral atrophy													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?							
3/7/68			SUBDURAL HEMATOMA, BILATERAL			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOJRY A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
			2/8/68			Fell at home							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No			City or Town				
			fell at home			220 N. Stricker Street, Baltimore, Md.							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			MELVIN B. DAVIS, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED				
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			4/2/68				
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
BURIAL			4-5-68			Baltimore - Cut			Baltimore - Virry				
24 FUNERAL DIRECTOR			Wilson Funeral Home			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE				
			Orleans Street, Baltimore, Md.			APR 4 - 1968			Charles Judge				



CERTIFICATE OF DEATH

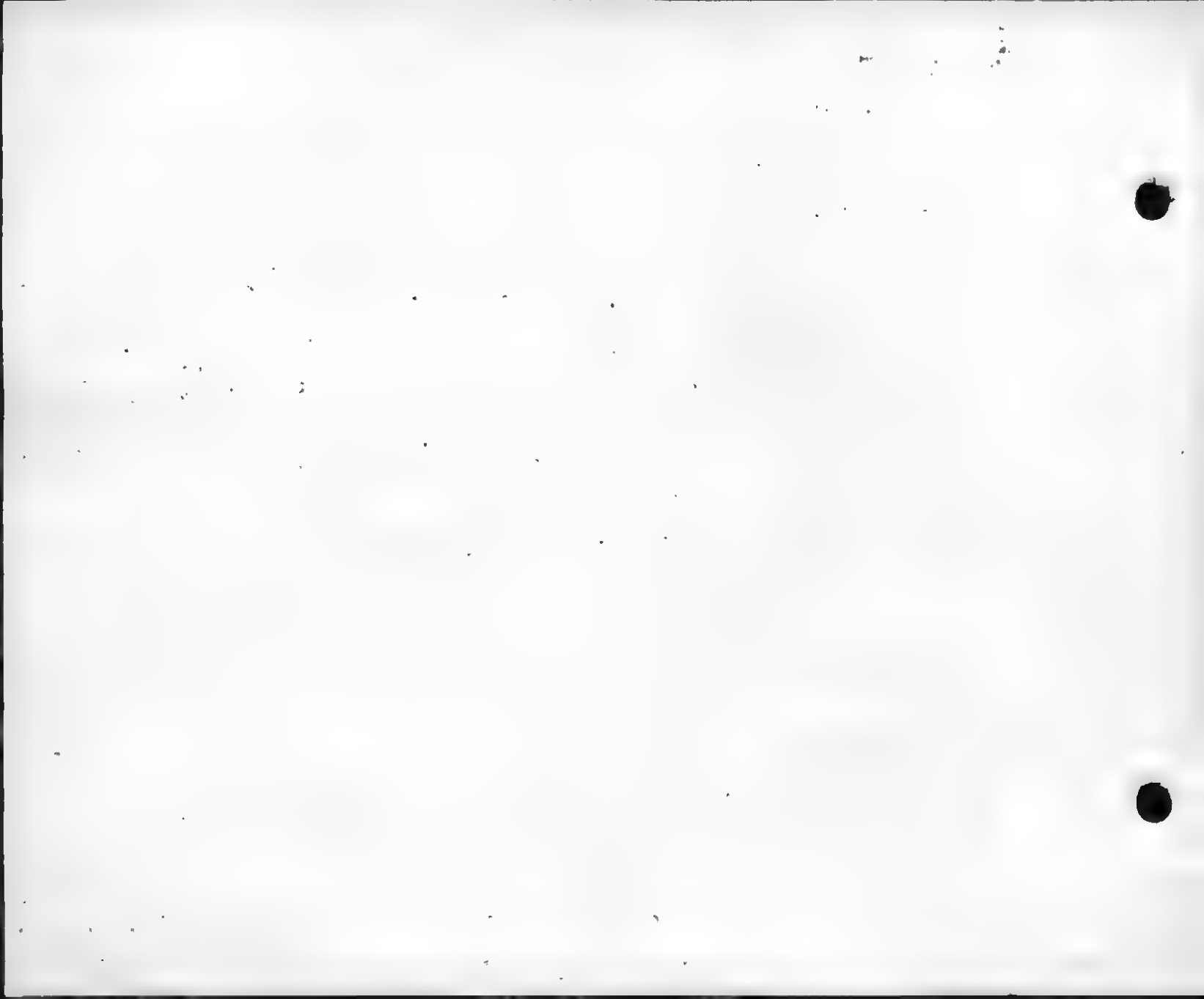
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

58223

1. DECEASED-NAME (Type or print) HELEN MILDRED WILSON			2a. DATE OF DEATH Month 4 Day 1 Year 68			2b. HOUR 4:58 M	
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH 10-15-12		6. AGE (In years last birthday) 55 YRS.	
7a. BIRTHPLACE (State or foreign country) BALTO., MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO. Co. Md	
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC			12a. USUAL OCCUPATION (Kind of work done during usual of working life, even if retired) HOUSEWIFE	
13a. USUA. RES DENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTOCTY		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1646 BALTO. MD. 21218				
14. FATHER'S NAME First Middle Last William H. SHELTON			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET GREEN SHELTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give date) NO			16b. SOCIAL SECURITY NO 216-01-5588		17. INFORMANT Address RUDOLPH L. WILSON (BAME)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 147 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemophysis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of pharynx APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4.1. 1968 to 4.1. 1968 , that (I) (we) last saw the deceased alive on 4.1. 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dipak Kumar Mallik				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4.1. 68	
22d. PHYSICIAN'S NAME (Type) DIPAK KUMAR MALLIK				22e. ADDRESS G. B. M. C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/1/68		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. Md.				25a. REC'D BY REGISTRAR APR 3 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



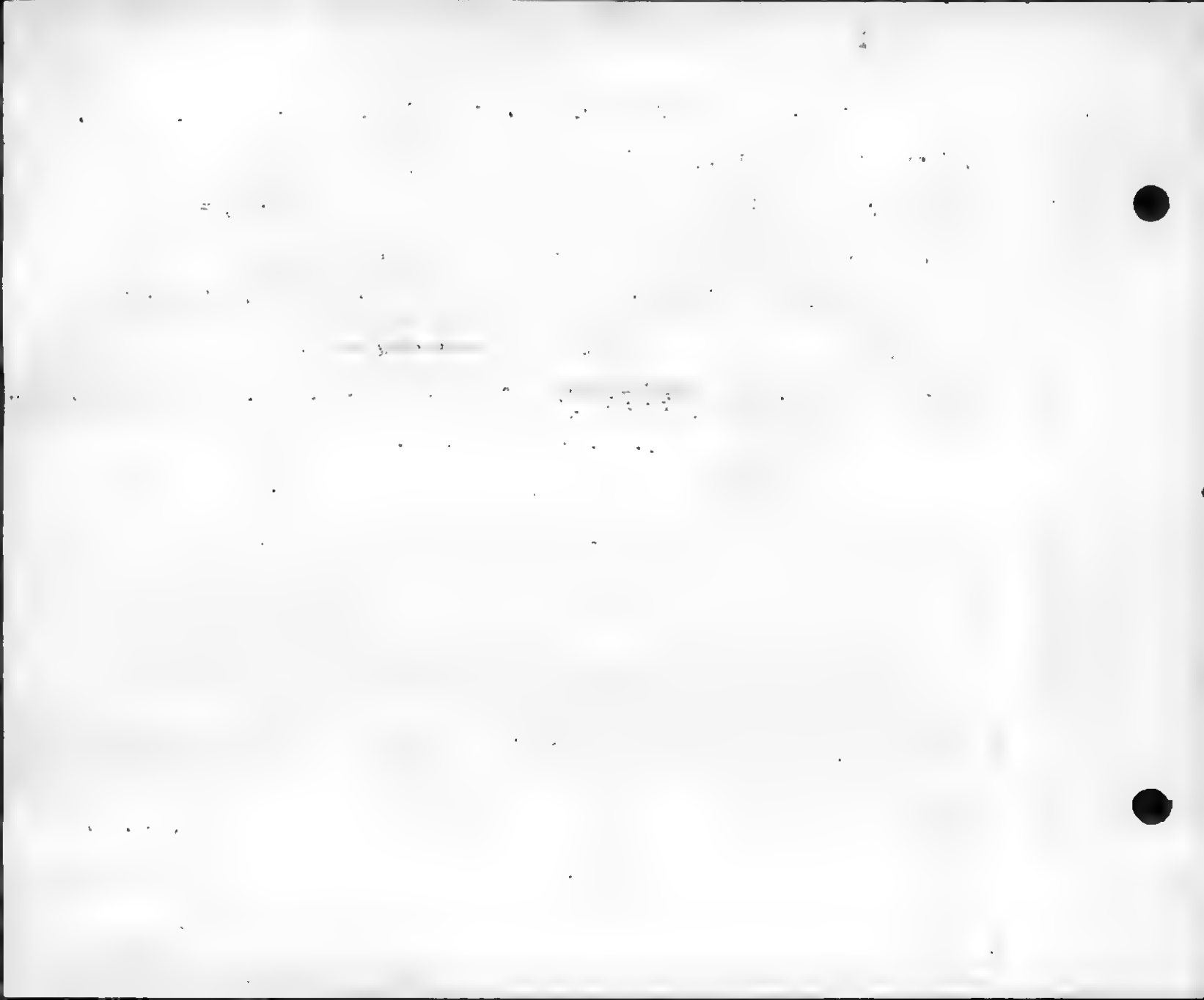
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

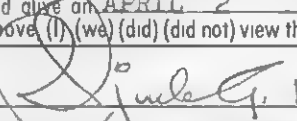

CERTIFICATE OF DEATH

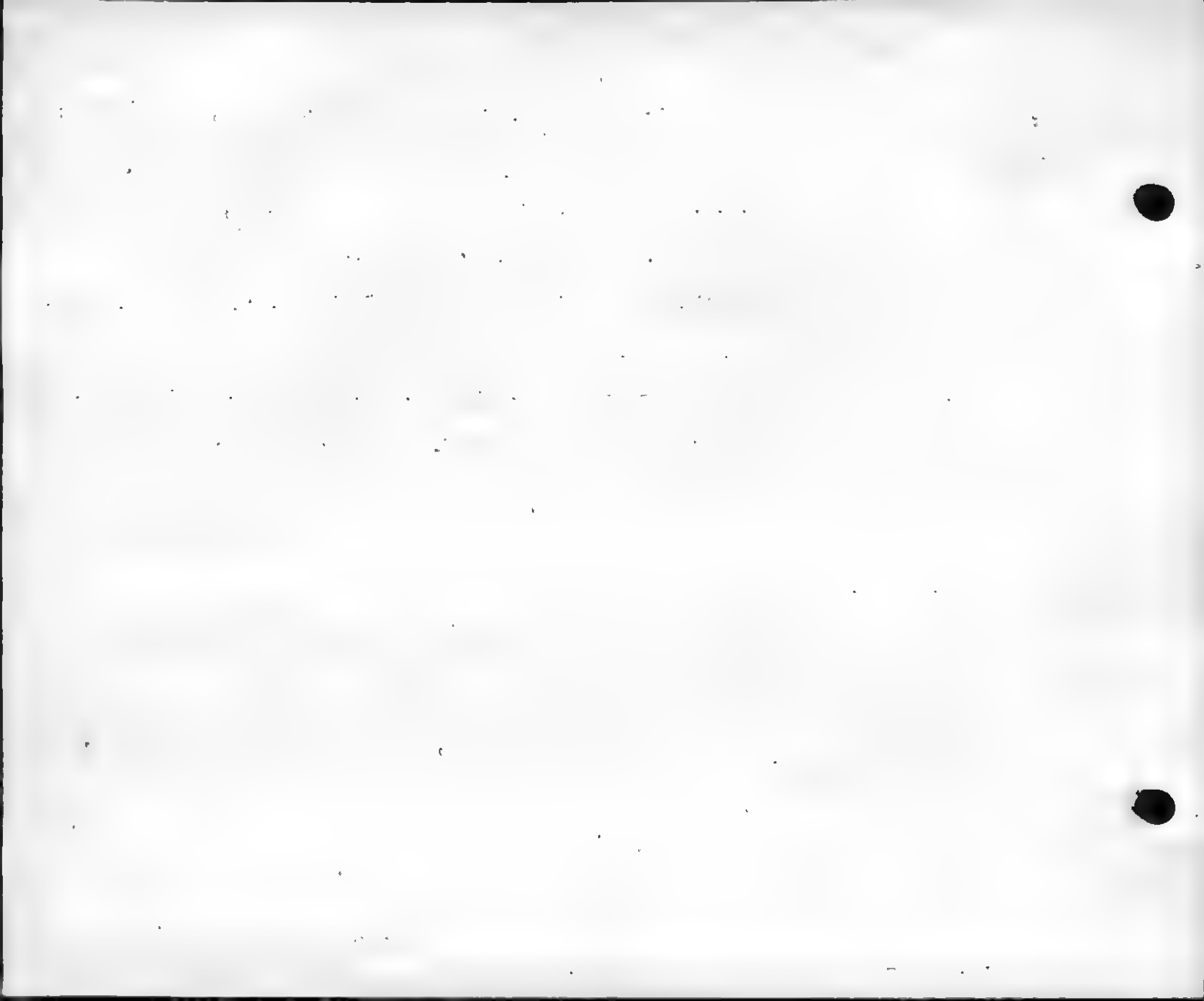
1. DECEASED-NAME (Type or print) ELSIE MARGARET WINEBRENNER			2a. DATE OF DEATH Month 4 Day 30 Year 1968			2b. HOUR 11:55 PM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 2/24/18		6. AGE (In years last birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARR. <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) G.B.M.C.		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIM TSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 9604 DIXON AVE.		14. FATHER'S NAME First Middle Last JOHN FRISBY		15. MOTHER'S MAIDEN NAME First Middle Last HOOVER MARGARET HOOVER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	
16b. SOCIAL SECURITY NO 218224523		17. INFORMANT PATIENT'S CHART /		17. ADDRESS 218224523		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) possible brain metastases DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Metastases DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Cervix Grade IV PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 4-29 , 19 68 , to 4-30 , 19 68 , that (I) (we) last saw the deceased alive on 4-30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE E.R. Soudijn	
22c. DATE SIGNED 5-1-68		22d. PHYSICIAN'S NAME (Type) E.R. Soudijn		22e. ADDRESS GRAETER BALTIMORE MED CENTRE		22f. SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/3/68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.		25a. REC'D BY REGISTRAR MAY 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> CE330 MARYLAND STATE DEPARTMENT OF HEALTH 05432 </div> <div style="text-align: center;"> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>												
1. DECEASED-NAME (Type or print)			First NAOMI		Middle MARGUERITE		Last WINTER		2a. DATE OF DEATH Month APRIL Day 2 Year 1968			2b. HOUR 2:50 M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 26, 1906			6. AGE (In years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE, Md						
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) HOMEMAKER Secretary			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN Timonium		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 324 E. TIMONIUM RD. #21093			
14. FATHER'S NAME First Thomas Middle U. Last Forrest			15. MOTHER'S MAIDEN NAME First Laura Middle Last Kuhne									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-44-9545		17. INFORMANT Address Mr. Ralph A. Wintef 324 E. Timonium Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis, primary in colon DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 1558												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Intestinal obstruction												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 22, 1968 , to APRIL 2, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 		22c. DATE SIGNED April 2, 1968		22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.								
22e. ADDRESS 7620 York Rd., Towson, Md. 21204												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/5/68		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md. Baltimore						
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR APR 3 - 1968		25b. REGISTRAR'S SIGNATURE 								



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and place in the folder.

1. NAME OF DECEASED (Type or Print) ISADORE (ISADOR) (ISIDOR) WOLFF		2. DATE AND TIME OF DEATH APRIL 6, 1968 12:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD BALTO CO		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 4315 LABYRINTH ROAD, APT. 1 B		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 4315 LABYRINTH ROAD, APT. 1 B	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1899
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALVAGE		9. AGE (In years last birthday) 68	
10B. KIND OF BUSINESS OR INDUSTRY METAL		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME NATHAN WOLFF	
14. MOTHER'S MAIDEN NAME GUSSIE TURNER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 214-16-4955		17. INFORMANT MR. HOWARD RUBIN, 4315 LABYRINTH RD.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized carcinoma 7 months ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) Carcinoma of Stomach 6 months (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months 6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
22. I certify that (I) (this hospital) attended the deceased from 3 11 1948 to 7 16 1968 that (I) (we) last saw the deceased alive on 4 16 1968 and that in (my) (our) opinion death occurred on the date(s) and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Israel Zinberg		23B. DATE SIGNED 4/6/68	
23C. PHYSICIAN'S NAME (Type) Israel Zinberg		23D. ADDRESS 4000 W. Northern Parkway	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-7-68	
24C. NAME OF CEMETERY or CREMATORY BETH YEHUDA ANSHE KURLAND		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1968		25B. NAME OF REGISTRAR SOL LEVINSON & BROS. INC.	
25C. FUNERAL DIRECTOR 6010 REISTERSTOWN ROAD, BALT		ADDRESS 21215	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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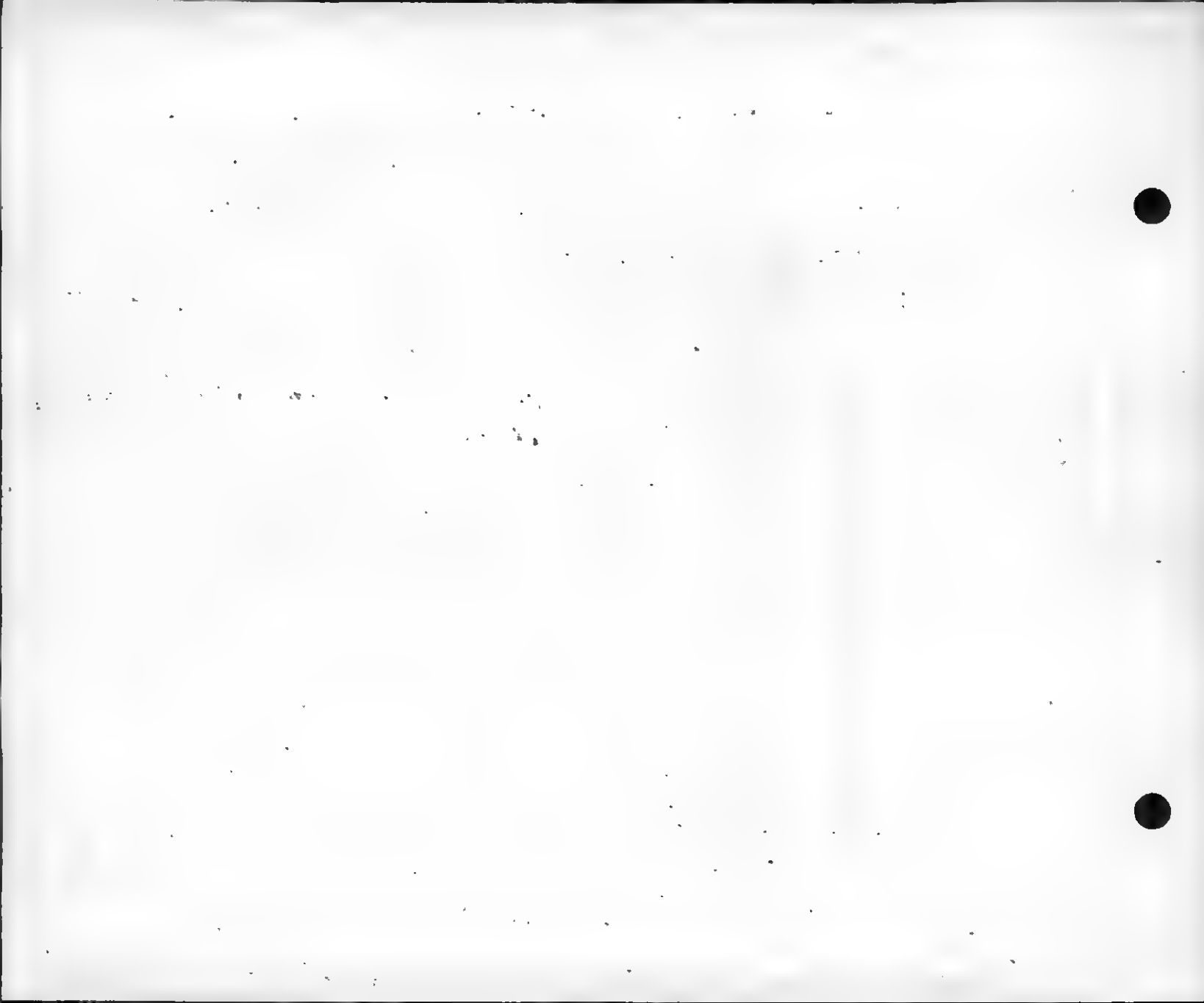
VR 1515
30M REV. 10-65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

35432

35434

1 DECEASED NAME (Type or print) CHRISTOPHER GUSTAV WOPPMAN			First Middle Last			2a DATE OF DEATH Month Day Year 4-11-68			2b HOUR M								
3 SEX M			4 RACE W			5. DATE OF BIRTH 12-11-1885			6 AGE (In years last birthday) 82 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE								
10 CITY OR TOWN OF DEATH BALTIMORE			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6719 CAMPFIELD RD.			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) PLAYGROUND ATT.			12b KIND OF BUSINESS OR INDUSTRY CITY								
13a USJA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b COUNTY BALTO.			3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 235 N. ROSE ST.								
14. FATHER'S NAME First Middle Last LAURENCE WOPPMAN						15. MOTHER'S MAIDEN NAME First Middle Last EMMA VATER											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.			17 INFORMANT Ms. AUGUSTA CUNNINGHAM			Address 6719 CAMPFIELD RD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIOSCLEROTIC & HYPERTENSIVE CARDIOVASCULAR DISEASE (b) C.V.A. DUE TO, OR AS A CONSEQUENCE OF (c) C.V.A. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HTN																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from April 11, 1968 , that (I) (we) last saw the deceased alive on April 11, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (dia) (dia not) view the body after death.																	
22b. SIGNATURE Andrew Leniscara			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4/13/68											
22d. PHYSICIAN'S NAME (Type) ANDREW LENISCARA			22e. ADDRESS 2607 E. BALTIMORE ST.														
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL			23b. DATE 4-15-68			23c. NAME OF CEMETERY OR CREMATORY DAK LAWN CEM.			23d. LOCATION (City or Town) (County) (State) BALTO., MD.								
24. FUNERAL DIRECTOR Walter Hill			ADDRESS -2334 Jefferson St.			25a. REC'D BY REGISTRAR DATE APR 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1-7-68

MD. 5433
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <i>Bessie Zalis</i>			2a. DATE OF DEATH Month Day Year <i>April 24 1968</i>		2b. HOUR <i>12:45</i> M
3. SEX <i>Female</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>February 3rd 1879</i>		6 AGE (In years lost birthday) <i>96</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <i>BALTIMORE</i> Md.		
10 CITY OR TOWN OF DEATH <i>PIKESVILLE</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MILFORD MANOR NURSING HOME</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>	13c. CITY OR TOWN <i>BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>3951 W. NORTHERN PKWY. #15</i>
14. FATHER'S NAME First Middle Last <i>SAMUEL FISHGOLD</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>ZALATA ?</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address <i>MR. ALBERT VANN-ZALIS, 2938 BARTOL AVE. #9</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral + coronary occlusions</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yes</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1940</i> , 19____, to <i>4/24/68</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/24</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Milton B. Kirsh</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/24/68</i>
22d. PHYSICIAN'S NAME (Type) <i>MILTON B. KIRSH</i>				22e. ADDRESS <i>4000 W. NORTHERN PKWY.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>4-25-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SHAAREI ZION</i>		23d. LOCATION (City or Town) (County) (State) <i>ROSEDALE, MARYLAND</i>	
24. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>				25a. RECD BY REGISTRAR DATE <i>APR 29 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

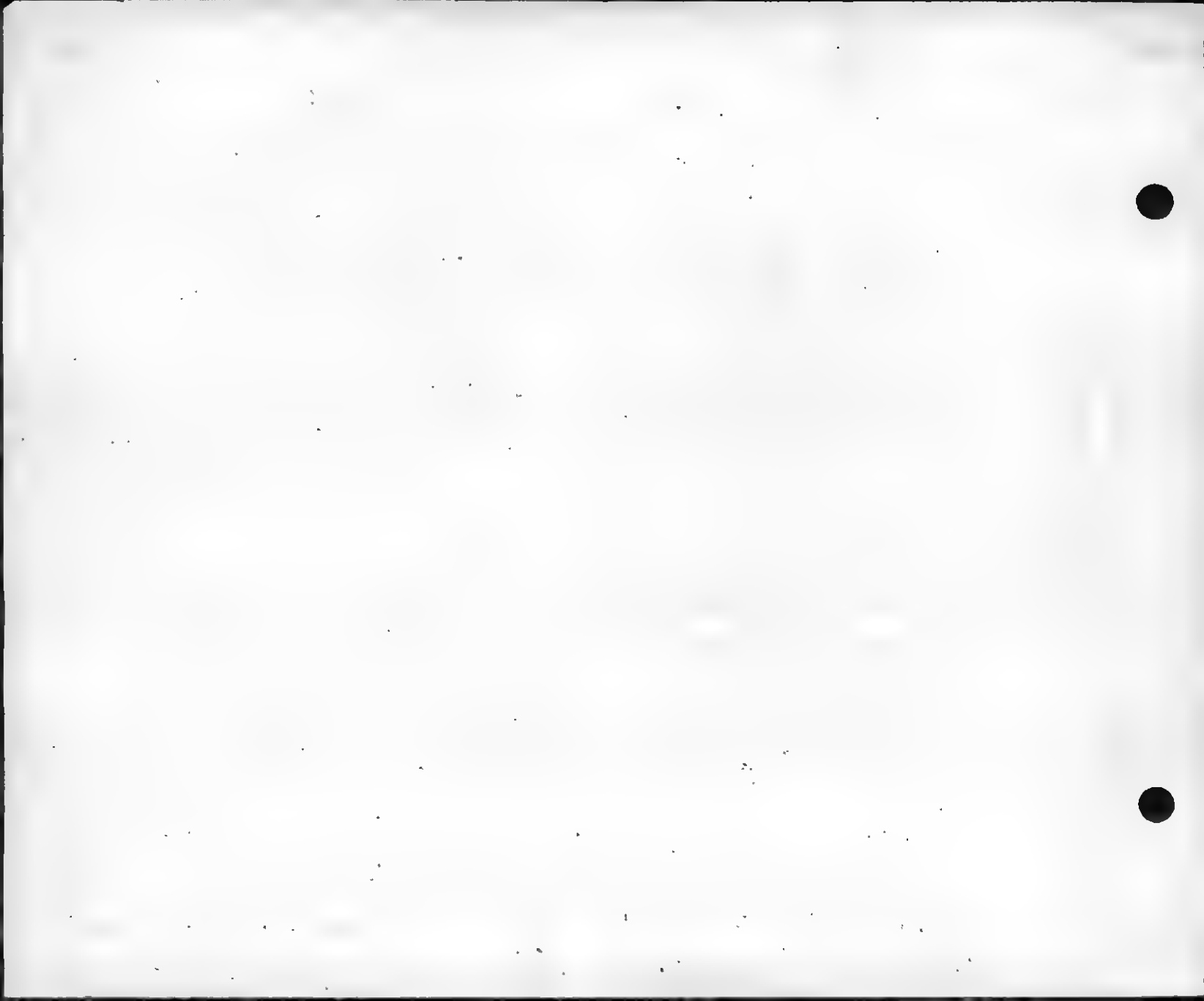
MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) William Albert Zepp			2a. DATE OF DEATH 4 Month 22 Day 68 Year			2b. HOUR 10:20 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 25, 1883		6. AGE (in years last birthday) 85 YRS	
7a. BIRTHPLACE (State or foreign country) md		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE md			13b. COUNTY Howard		13c. CITY OR TOWN SYkesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First William - Middle - Last Zepp			15. MOTHER'S MAIDEN NAME First Lucille - Middle - Last Arrington				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO ?		17. INFORMANT Name Mr. Wilbur Zepp Address SYkesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1) Acute Coronary Thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/22/68							
PART 2. OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from 3/16/68 , 19____, to 4/22/68 , 19____, that (I) (we) last saw the deceased alive on 4/19/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE B. Martin Middleton M.D.				22c. DATE SIGNED 4/22/68		22d. PHYSICIAN'S NAME (Type) B. MARTIN Middleton	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-25-68		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Howard Co. Md.	
24. FUNERAL DIRECTOR Name Harry W. Waight Address Sylva, Md.				25a. REG'D BY REGISTRAR DATE APR 25 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

05435

05437

1. DECEASED-NAME (Type or print) GEORGE FRANK ZIELINSKI, SR.			First Middle Last			2a. DATE OF DEATH April 14, 1968			2b. HOUR 4:25 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH Dec. 1, 1889			6. AGE (In years last birthday) 78 YRS.		
7a. BIRTHPLACE (State or foreign country) Balto. Co., Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Middle River			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and no.) My Hall Convalescent Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Chase			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER Eastern Ave. & Brinkman Rd.			13f. RURAL Rural			14. FATHER'S NAME Jacob Zielinski			15. MOTHER'S MAIDEN NAME Katherine ?		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 219 36 2242			17. INFORMANT Andrew Zielinski			Address Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 151.9 DUE TO, OR AS A CONSEQUENCE OF (b) gastric carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 151.8											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from January, 1966 , to April 14, 1968 , that (I) (see) last saw the deceased alive on April 6, 1968 , and that in (my) (see) opinion death occurred on the date and hour and from the causes stated above, (I) (see) (did not) view the body after death.											
22b. SIGNATURE See Stern									22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) Samuel Stern, M.D.									22e. ADDRESS Fuller Medical Group Ridge Rd. Balto. 6		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/18/68			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.		
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.						25a. REC'D BY REGISTRAR DATE APR 16 1968			25b. REGISTRAR'S SIGNATURE J. Charles Jones		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]



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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05436

05438

1. DECEASED-NAME (Type or print) WILLIAM J. ZOELLER			2a. DATE OF DEATH APRIL Month 5 Day 1968 Year			2b. HOUR 10:05 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/25/1899		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Crane Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Armco Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 8216 North View Rd.		13f. CITY OR TOWN 21222		13g. STATE Md.		13h. ZIP CODE 21222	
14. FATHER'S NAME First Middle Last Francis V. Zoeller			15. MOTHER'S MAIDEN NAME First Middle Last Lydia E. Duffy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give war or dates of service) WW I	
16b. SOCIAL SECURITY NO. 215-07-4168			17. INFORMANT (Son) Mr. Joseph D. Zoeller,			Address Newington, Conn. 46 Brockett St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from March 24, 1968 , to April 5, 1968 , that (X) (we) last saw the deceased alive on April 5, 1968 , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jose Nepomuceno</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 5, 1968	
22d. PHYSICIAN'S NAME (Type) Jose Nepomuceno, M.D.				22e. ADDRESS 7620 York Rd. Towson, 21204, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/8/68		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

